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THE UNIVERSITY OF ALBERTA

THE DEVELOPMENT OF NURSING EDUCATION IN TRINIDAD AND TOBAGO: 1956-1986

BY

© JOCELYN AGATHA HEZEKIAH

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES
AND RESEARCH IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

DEPARTMENT OF EDUCATION ADMINISTRATION
EDMONTON, ALBERTA
SPRING, 1987

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External Examiner

Date ......March 10, 1987........

DEDICATION

To Michael whose life touched mine at a crucial time.

ABSTRACT

The purpose of this study was to describe and analyze the development of nursing education in Trinidad and Tobago from the period of self-government to 1986, with special emphasis on the forces and factors that helped to shape the society and, consequently, nursing education. Because of the nation's historical legacy of colonialism and its current linkages with the United States and Canada, a major area that was fundamental to the analysis was to determine whether these two countries had superseded traditional British influences in determining health care policies and nursing education. This raised the issue of whether or not the education of nurses could be autonomously determined to meet the needs of the people.

This was an interpretive case study utilizing a qualitative mode of enquiry. Data were collected through documentary search and interviews with key individuals who were involved in nursing and health care.

The theoretical framework employed was derived from a view of development that falls under the broad tradition of dependency theory and theories of colonialism. Adaptation and application of those theories formed the basis of the study's theoretical framework which posited that nursing was dependent on the ideas and values of the metropolitan countries for the development of nursing education programs, policies, and nursing services. Analysis of the findings was conducted within this theoretical perspective.

Findings indicated that psychological and administrative factors inherited from the nation's colonial past persisted in the post-independence period but, as well, there were political and economic factors in the era of the national government that promoted as well as hindered the progress of nursing education. The latter was related to the image, status, and powerlessness of nursing as a predominantly female occupation, and the nature of policy-making adopted by the government which favored incremental changes similar to its inherited colonial pattern.

Further, while nursing education and practices were based on British ideas and values in the colonial era, with political independence, the United States and Canada became the dominant sources of ideas and values in influencing curriculum development and program changes. Nursing practice was, however, slow in effecting changes and retained much of the British tradition.

Throughout the development of nursing education, key figures and events, locally and in the British Caribbean region, played a significant role in promoting reforms and advances for the profession. Nursing education was consequently an amalgam of British, North American, and indigenous features.

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CHAPTER I

OVERVIEW OF THE STUDY

A. Introduction and Need for the Study

While the developing countries are in many essential ways different from each other, yet there are some important similarities in that they all have common development problems to solve. These find expression in such ~~forms~~ as low per capita income, high incidence of malnutrition, illiteracy, poverty, and high mortality and morbidity rates, to name but a few. Their common historical legacy of domination and exploitation by such metropolitan powers as England, France, Spain, and Portugal during the mercantile period saw these countries struggling, in the latter part of the nineteenth and in the twentieth centuries, to free themselves from the shackles of colonialism and dependency. Yet, it was not to be, because while political independence has been achieved for most countries, economic dependence remains for all as they struggle to "develop."

Within the last two decades, many of the Caribbean islands have gained independence, and for the first time West Indians are now shouldering the arduous task of directing their own destinies after three and one-half centuries of colonial domination. Recent years have witnessed an increasing emphasis by West Indian scholars on recording and analyzing the struggles for freedom and independence in Caribbean societies.

To accomplish the goal of national development and to achieve some degree of national identity, it is recognized that West Indians will require a knowledge of their past together with an understanding of the present. The lessons to be learnt from history are important to an understanding of modern day Caribbean society and to meeting the challenges of the future.

In nursing, where research in general is yet in its infancy, there is a dearth of historical data available to the researcher or the practitioner. Newton (1965:22) noted that nurses were characteristically "doers" and were often action-oriented. They, therefore, readily accepted research that resulted in recommending more effective nursing procedures or changes to a curriculum that would lower state board examination failures. Their concern was with the pragmatic. Consequently, there was little cultural, philosophical or historical enquiry carried out in connection with their work. She, therefore, argued that there was an urgent need for more historical research in nursing. Such research is needed as guardian of tradition, a guide for the present, and creator for the future. Nursing research of a historical nature provides nurses with a knowledge and understanding of the contributions of their professional colleagues and associations to the growth of the profession. Further, provides information about the social, political, and economic forces which have shaped the profession. Ashley (1978:29) was critical of the historical research undertaken so far and asserted, "historical research in nursing has, to date, consisted of purely descriptive reporting of data without conceptual analysis of their meaning for nurses and society." She further argued that the research had been insular, as there had been an absence of references to documents outside the field to allow for a better understanding of the meaning of professional events in the context of society as a whole. These concerns expressed about historical research in nursing become more critical in the Caribbean where nursing research is in a preliminary stage. Societal changes and health policies affect the responsibilities and education of nurses. How to prepare nurses effectively and efficiently for the present and the future to meet the needs of the society is, therefore, of central importance. Accompanying this concern is the desire to apply new ideas about learning, teaching, and curriculum development.

In Trinidad and Tobago, basic nursing education is currently organized with two streams leading to registration, either as a registered nurse or a registered psychiatric nurse, through the Nursing Council of Trinidad and Tobago. Students spend the first eighteen months in common, and the last eighteen months in general nursing or psychiatric nursing. These programs lay the foundation on which all other nursing education programs are based.

There are four post-basic nursing programs:

1. A program in general nursing for the registered psychiatric nurse and one in mental health nursing for the registered general nurse. These are reciprocal programs of eighteen months in length.
2. A midwifery program - one year in length.
3. A community health nursing program - nine months in length.

4. Courses in nursing education - to prepare teachers for the Nursing Assistant program. These courses are organized over a period of ten months.

The midwifery program and the mental health nursing program are certified through the Nursing Council. There is also a two-year Nursing Assistant program leading to enrolment with the Nursing Council of Trinidad and Tobago. Additionally, plans are underway to introduce advanced nursing courses at the university level locally. The need to document, analyze, and develop this major aspect of Caribbean society was the motivating factor that precipitated this study.

B. Purpose of the Study

The purpose of this study is to describe and analyze the development of basic nursing education in Trinidad and Tobago from self-government to the present time. To do so required an understanding of the evolution of nursing education in historically earlier periods, with special emphasis on the forces that helped to shape the society, and consequently nursing education.

Because of the nation's historical legacy of colonialism, and its current linkages with the United States and Canada, a major area which is fundamental to the analysis is whether the United States and Canada have superseded traditional British influences in determining health policies, and specifically that of nursing education. This raises the issue of whether or not the education of nurses can be autonomously determined to meet the needs of the people.

The general area of enquiry is formulated in the following research questions:

1. What are the social, economic, political, cultural, and demographic forces that have helped to shape nursing education policies since independence?
    - .1 What have been the major sources of British influence on nursing education programs in Trinidad and Tobago?
    - .2 Have these been replaced by the United States and Canadian influence and, if so, by what mechanism is this being done?
    - .3 What are the indigenous influences on nursing education?
    - .4 Who are the principal actors with regard to health care policies?
    - .5 Who are the principal actors with regard to nursing education policy planning and implementation?
    - .6 To what extent is nursing education influenced or directed by health care policies?
    - .7 What is the influence and/or input of nursing into health care policies?
2. To what extent have the values and social organization of the society been reflected in nursing education policies and programs since independence?
    - .1 In what way or ways are the values of the society expressed in nursing education?

.2 How are these values determined and who determines them?

.3 How is the prevailing class structure reflected in nursing education?

.4 Who are the decision-makers with regard to curriculum content?

C. Significance of the Study

Within the last few decades there has been an increasing number of studies on nursing and nursing education, yet the literature is still severely limited. The relatively few studies that focused solely on nursing education in the United States and Canada have been by surveys. One of the earliest in the United States was the Goldmark Report (1923) which was commissioned by the Rockefeller Foundation to investigate conditions in Schools of Nursing. It recommended that more attention be devoted to the educational preparation of nurses, that admission requirements be raised significantly, and that federal grants be provided to assist schools of nursing in raising educational standards.

At about the same time in Canada, a national survey of nursing education was conducted by Dr. George Weir (1932), educator and sociologist. The recommendations, similar to those in the United States, were to change the system of nursing education by removing nursing schools from hospital control, and to bring the education of nurses into the general education system of the province. While there have been subsequent studies on nursing education that have not been surveys, these have rather focused on specific problems. For example, in 1962 The Royal Commission on Health Services conducted a study on Nursing Education in Canada. The main purpose of that study was to examine and analyze all types of educational programs for personnel providing nursing care. In more recent times, Allemang's (1974) study surveyed nursing education in the United States and Canada from 1873 to 1950, focusing on nursing leaders.

Other studies have been American (Boudreaux, 1980; Cristy, 1980; Davis, 1976; Sloan, 1979). Herrmann's (1979) and Hay Ho Sang's (1984) are two of the few studies on nursing education in the Caribbean area. Both identified the persons, organizations, and events integral to nursing education. Herrmann (1979) focused on Belize from 1920 to 1970, and Hay Ho Sang (1984) on Jamaica from 1900 to 1975. The major thrust of the vast majority of historical nursing dissertations has been to describe the development of a particular university, college or diploma nursing program. There have been relatively few that have examined nursing education on a broader scale in terms of a particular country or countries. Moreover, most of these have focused on the contributions of nursing leaders and organizations to the development of nursing education.

Norman (1981), after arguing that nurses must begin to investigate important periods in their history, went further and suggested some general categories of concerns to which such studies could be directed. These included:

> the role society allotted to women at a certain point in time, the influence of technology or war on the role of the nurse, and

> the social and economic factors that might have influenced nursing education (p. 150).

These were deemed relevant to current nursing problems and worthy of investigation.

This study addresses some aspects of these problems within the context of a developing country. Firstly, the study identifies factors which have historically contributed to the development of basic nursing education in Trinidad and Tobago. As such, it provides a body of knowledge which could assist the nurses of Trinidad and Tobago in the future planning and administration of nursing education and health care. Secondly, a study of the past disclosed which traditions have proved most valuable and need to be protected and those which have undermined progress in nursing. Thirdly, it can help to give nurses a feeling of belonging and identification and encourage group pride. Finally, it can be useful to nursing education administrators and health care planners in other third world countries which share a colonial heritage.

D. Delimitations of the Study

1. The study was confined to the period from self-government (1956) to the current time (1986), although for the purposes of clarity and continuity it was necessary to refer to events preceding 1956.
2. Only major participants in nursing education were identified and interviewed.

3. The study was delimited to a case-study of only one nation state--the twin islands of Trinidad and Tobago.

4. The study was delimited to an analysis of basic nursing education for the registered nurse.

E. Limitations

The study was limited by the following factors:

1. The data gathering techniques which relied on the impressions and memories of people of past events through interviews.

2. The amount and availability of official and unofficial documents.

3. The researcher's constraints relative to time, geography, and finances.

4. Its exclusion of analysis of other health care personnel who delivered nursing care.

F. Organization of the Study

This thesis is organized into eight chapters. The first chapter provides an overview of the study. The need for the study, the purpose and significance of the study as well as the delimitations and limitations are described. Chapter II describes the methodology and the research approach used. As well, the research design which guided the collection of data and some issues of methodological rigor are discussed. Chapter III reviews the literature on development theory and theories of colonialism which provided the basis for the conceptual framework for the study.

Chapter IV is divided into two sections. Section I provides a brief historical overview of the British West Indian society. Section II explores in greater detail the Trinidad and Tobago setting placing emphasis on its political, economic, and social development from its discovery in 1498 to the 1980s. The emphasis in both sections is placed on major political changes and their relationship to the economic and social characteristics of the society.

Chapter V presents the early development of nursing education in the colonial era.

Chapter VI describes nursing education since the country became self-governing. It considers the major forces which influenced the development of nursing education. Chapter VII is an analysis of the major findings provided from the study's theoretical perspective. The final chapter provides a summary of the study and reflects on the value of the theoretical framework. It also offers some conclusions and recommendations.

CHAPTER II

RESEARCH METHODOLOGY

This was an interpretive case study using a qualitative mode of enquiry. In this chapter, a background to the case study approach is presented along with the methodology of data collection and data analysis.

A. The Case Study Method

The case study is often the preferred method in social enquiry studies. In defense of the case study approach, Blau (1955:302) suggested that social processes could be examined more directly by this means. He argued that the case study approach was more likely to yield reliable and systematic data than any other methods, and it was possible for the researcher to move back and forth between analysis and data gathering stages. Furlong and Edwards (1978) noted further that it was possible to pinpoint critical processes and identify common phenomena through the detailed study of one particular context.

Bogdan and Bixlen (1982:58) concurred with that conception and defined it as a "detailed examination of one setting, or one single subject, or one single depository of documents, or one particular event." As well, Fairchild (1962) posited that the case study method was:

> The method used in social research whereby data are collected and studied which depict any phase of a, or an entire, life process of a unit in its various relationships, and in its cultural setting. The unit studied may be a person, a family, a social group, a social institution, a community or a nation. In contrast to the statistical method, the case study method gives a more or less continuous picture through time of the experiences, social forces and influences to which the unit has been subjected. (My emphasis.)

Similarly, Shaw (1978:2) observed that case studies are useful in research because attention could be focused on how particular groups of people dealt with specific problems. Guba and Lincoln's (1981:371-373) characteristics of historical case studies apply in this study:

1. a case study provides "thick description."
2. a case study is holistic, presenting a picture.
3. a case study is focused.
4. a case study illuminates meanings, focusing the reader's attention.
5. a case study builds on the "tacit knowledge" of its readers, thus gives a sense of the actual substance of the case.

Heclo's (1972:83-108) observations, while addressing policy case studies, also have relevance. He contended that the greatest area of promise in case studies was their "ability to move" with the reality of dynamic factors. By relating events to antecedents and contexts, the case study technique could identify new relationships rather than simply descriptions of the particular event. A further potential usefulness was the richness and flexibility of analysis which was available in case studies. In terms of technical tools, the approach could integrate existing historical studies, secondary sources, aggregative quantitative data, and interviews.

Campbell (1974:24-25), one of the critics of the case study approach, had renounced his earlier harsh judgment about the "single occasion" single setting (one shot case study) by observing how

> acquaintance with events and persons, extended across time and settings provides even the quantitative scientist with qualitative knowledge that enables him to catch misunderstanding, error, and fraud in his data.

Salisbury (1968), as well, argued with critics of the case study in its implementation for research strategy, by stating that there appears to be nothing about the case study technique which is inherently non-theoretical or unscientific.

The case study approach was particularly suited to conducting this study of the development of nursing education in Trinidad and Tobago as it permitted an "in-depth examination of a particular instance of something. It presented a detailed rendition of a particular dynamic instance." The case study told a story (Hofferbert, 1979:89).

B. Qualitative Research

Within the last two decades there has been a resurgence of interest in qualitative research. Researchers have been turning toward qualitative methods to gather information about human behavior that was inaccessible to the more quantitative. Qualitative research was predicated upon the assumption that an "inner understanding" enabled the comprehension of human behavior in greater depth than was possible from the study of surface behavior, from paper and pencil tests, and from standardized interviews (Rist, 1979:20). The naturalistic/qualitative paradigm was viewed as an alternative to the scientific/quantitative paradigm that had prevailed for so long in educational research (Guba, 1978). Owens (1982) indicated that the qualitative method allowed the researcher to get close to the data thereby developing analytical, conceptual, and categorical components of explanation for the data itself.

Bogdan and Bixlen (1982) agreed and pointed out that educational research was changing and that a field that was once dominated by measurement was moving toward one that emphasized inductive analysis. They cited a number of characteristics of qualitative research methods:

1. Qualitative research is descriptive and reported in anecdotal or narrative form.
2. Qualitative research has the natural setting as the source of the data, emphasis is placed on the content and the history of the institutions.
3. The tendency is to analyse data inductively, from specific instances to general applications of concepts. These emerge from the data as opposed to being established prior to the study.
4. The data collection often determines the direction of the study. Thus, the research design has flexibility.
5. Meaning is of essential concern to the qualitative approach.
6. The researcher is the key instrument. Open-ended interviews are typically used in gathering data (1982:27-30).

The case study approach as one of many qualitative research methods bases its interpretation on an understanding of the subjects from their own point of view. It is a technique which provides descriptive data allowing a view of the world as the subjects see it. Further, as Van Manen (1979:520) indicated, "qualitative" has no precise meaning, rather it is an umbrella term, including numerous interpretive techniques. The case study is such a technique because it attempts to describe the meaning of naturally occurring phenomena in the social world.

C. Data Sources and Data Collection

The data used in this study were obtained from two main sources:

I. Primary Sources

These included:

(a) semi-structured interviews which were taped and later transcribed;

(b) official documents in the form of reports and minutes of meetings;

(c) non-official documents as personal records and notations.

II. Secondary Sources

These included books, an unpublished thesis, journal and newspaper articles, and radio broadcasts which were political, economic, social, and cultural in nature.

Interviews served to document individual perspectives on aspects relevant to the study and to provide data which were not available in documents.

Interviews followed a semi-structured format. The interview guide consisted of open-ended subsidiary research questions rather than a rigid list of questions. This method facilitated the free flow of conversation and permitted exploration of new aspects that arose spontaneously during the interview. Kerlinger (1967:471) pointed out that open-ended questions provide "a frame of reference for respondents' answers, [but placed] a minimum of restraint on the answers and their expression." Interviewees also referred the researcher to relevant documents. Interviews were conducted with 24 persons. All were Trinidadians or Tobagonians by birth except for one expatriate who was a naturalized Trinidadian. All were involved with nursing education and health care either prior to, or since self-government of the country.

Key interviewees were initially contacted in writing by the researcher. The technique followed for the selection of interviewees was the reputational approach. This involved asking a small group of persons who were known by the researcher to be knowledgeable with the situation and events that were to be researched to name others whom they considered to be like themselves--key informants. This identification and interviewing process was repeated until a saturation point was reached (McCall and Simmons, 1969). In Trinidad those key persons and subsequent interviewees were contacted by telephone. They were told the purpose of the study and the reason for requesting the interview. All agreed to the interview. Two persons were interviewed twice because of time constraints at the first interview and for further information. Further, as the researcher attempted to pursue aspects of the study that had emerged more exploration was required.

The interviews were conducted primarily in the respondents' office with only four in other settings. Of these, three were conducted in the respondents' home, and one in the office of the researcher's brother. A friendly, informal, non-threatening approach was used in the interviews. Respondents were most cooperative and volunteered information freely. All interviewees save one granted permission to tape the interview. The respondent who refused was nervous about using a recorder and felt it would be inhibiting. Her wish was respected by the researcher.

Following the interviews, the tapes were transcribed and returned to the interviewees for validation. The researcher contacted the subjects if further questions arose after the transcription. The tapes and a master copy of each interview were kept.

Primary sources, such as reports, memoranda, minutes of meetings, working papers, speeches for public presentation, policy statements, personal records, and notations were used extensively. These were supplemented by the interview data. Secondary sources such as a radio broadcast and an unpublished thesis, or newspaper items were used in instances where primary sources were unavailable.

Data from the documents and interviews were analyzed and categorized according to the views of the interviewees in relation to the questions. Historical documents provided the basis for Chapter IV.

D. Methodological Rigor

Problems of reliability, validity, and objectivity face all those who are engaged in scientific enquiry. It poses particular problems for those accustomed to enquiry in the positivistic vein.

Guba and Lincoln (1982:246-247) supplanted the traditional rationalistic criteria with the following naturalistic analogues: credibility for internal validity; transferability for external validity; dependability for reliability; and confirmability for objectivity.

Credibility refers to the degree of confidence in the findings of a particular enquiry. Because naturalistic research considers social realities as subjectively constructed in the minds of people, the crucial concern is whether the sources agree with the researcher's analyses, formulation, and interpretations.

Transferability refers to generalization of findings to larger or other populations. The naturalist discounts such generalizability except in a limited sense where there is substantial similarity between two situations. Transferability, however, is possible if there is enough "thick description" to make a "reasoned judgment" about transferability. Further, Guba and Lincoln (1981:62) believed that it was not possible to develop "truth" statements that have general applicability on the grounds that nearly all social/behavioral phenomena are context bound. They concluded that the researcher should be wary of generalizations in all areas.

Dependability refers to stability of data achieved through the use of "overlap methods," that is, two or more data collection procedures. These enhance the reliability factor as well as validity.

The onus of objectivity is placed on the confirmability of the data instead of attempting to attribute objectivity to the researcher. As well, the important step of "practicing reflexivity"--the uncovering of the researcher's own underlying assumptions, reasons for formulating the study in a particular way, and implicit biases or prejudices about the context or problem (Guba and Lincoln, 1982:248) are suggested.

Triangulation, a process whereby a variety of data sources, different theories or perspectives, and different methods are pitted against one another to crosscheck data and interpretation (Denzing, 1978:292) is advocated by Guba and Lincoln (1982:247) as an assurance of methodological rigor. As well, Jick (1979:608) suggested that "the effectiveness of triangulation rests on the premise that the weakness in each single method will be compensated by the counter-balancing strengths of another."

In this study, interviews, official and non-official documents led to triangulation to assure credibility, dependability, and confirmability. Credibility or internal validity was assured due to the degree of agreement between the data from the documents and the interviews. As well, the interviewees were extremely congruent which is not unusual, as some of the interviewees were involved in the preparation of the documents utilized and regularly interacted in the delivery of nursing services.

Dependability was assured because of the overlap of the data gathering methods which produced "complementary results." Guba and Lincoln (1982:247) also suggested establishing an "audit trail." This makes it possible for an external auditor to examine the processes used during the study and thus verify accuracy of the study. This process was followed by keeping an "audit book" of the interviews as well as the tapes and transcriptions. These materials can be used by an external auditor to verify the accuracy of the study.

Guba and Lincoln (1982:248) also advocated the use of purposive sampling and thick description to facilitate transferability. In this study, the snowball sampling technique was employed to "maximize the range of information collected." Thick description was achieved by providing enough information about nursing education in Trinidad and Tobago to allow judgments about the transferability of the process of development of nursing education to similar situations.

Because the researcher was Trinidadian in origin, she was particularly conscious of the need to acknowledge her biases and implicit assumptions concerning the social and political context of the study. While the researcher is proud of her heritage, she retains some measure of ambiguity towards her colonial masters, similar to most of her Caribbean cohorts. She acknowledges the benefits of her colonial education yet she is most sensitive to the deprivation in her education of a knowledge, understanding, and appreciation of her Caribbean historical past. These expressed beliefs may carry unavoidable tones which have their roots in the Caribbean culture. On the other hand, because of her origin, it enabled her to gain access not only to personnel who might otherwise not have readily done so but, as well, to data.

Summary

This chapter presented an overview of the research methodology and the study design. A discussion of the case study method as it applied to the study of a single nation state was placed in the context of qualitative research. Data sources and data collection techniques were presented. Data from interviews served to supplement as well as to cross-validate data collected from documentary sources. Methodological rigor was discussed and triangulation was proposed as a means of ensuring "trustworthiness."

CHAPTER III

REVIEW OF THE LITERATURE

In this chapter a review of some of the relevant literature is provided. Literature on theories of development, and colonialism is reviewed. Major views from these theories are examined and constitute the basis of the theoretical framework for this study.

Theoretical Framework

Interpreting the evolution of nursing education in Third World countries requires a theory of development. Such a theory is necessary for an understanding of these societies and their attempts at effecting changes in their substructures to promote development. Theories of imperialism are used by many scholars to analyze ideas and institutions which become adopted by the developing countries, as the essence of imperialism is that of domination and subordination. This domination of the metropolitan countries over the developing nations has created not only economic structures of dependency, but also cultural, social, psychological, and intellectual forms of dependency. Williams (1970), a renowned Caribbean politician and historian, observed that dependence on the outside world for economic aid has led to dependency in all structures of the society. He asserted "political forms and social institutions were imitated rather than created, reflecting the forms of the metropolitan country" (p. 500).

It is posited that nursing education and health care in Trinidad and Tobago are the result of an intellectual and cultural dependency of this Third World country on Great Britain, and later on, the United States and Canada which are the dominant sources of ideas and values for policies and programs.

An understanding of the theories of development is, consequently, a necessary precursor to a clearer appreciation of the development of these other forms of dependency.

A. Theories of Development

There are two major groups of scientific theories of development--the early theories of imperialism which gave rise to theories of dependency and colonialism, and the liberal, evolutionary theories from which evolved the neo-evolutionary or modernization theories of the developed nations which prevail as the dominant world view.

The origin of modernization theory can be traced to nineteenth century models which attempted to obtain scientific understanding of social life. All human societies were assumed to follow a singular particular course between the two ideal polar types--from a simple "primitive" to a complex "modern" society. Neo-evolutionary theory, of which Durkheim and Parsons are the leading proponents, elaborated on the earlier evolutionary model. Social evolution was seen as a process of increasing complexity of human social life labelled "social differentiation." This neo-evolutionary way of thinking about development was also evidenced in Rostow's "stages of growth" in the

1960s. His stages of growth was seen as a prescription for the stable modernization of the Third World. The world's poor should imitate Western capitalist styles of development with aid playing a dual role of catalyst to rapid economic growth and a cushion to the social and political shock of the forced march to modern industrialization. There were natural, logical, orderly, linear stages of growth which all societies undergo in the process of their transformation into modern societies. His thesis was that aid could help underdeveloped countries achieve a "take-off" point by emphasizing the accumulation of savings. The acceleration of growth was advocated at the expense of income distribution, and the concentration of aid efforts in those countries closest to the "take-off" point (Carty and Smith, 1982:76). Economic development of the Third World was viewed as both beneficial to the developing countries and a good source for capital investment generally in the developed world.

Another widely held conception of development, emanating from the developed countries, viewed development as occurring through the diffusion of cultural elements from the developed to the developing countries. Diffusion of knowledge, skills, values, technology, institutions, organization, and capital were seen as the key factors for economic development and cultural change. In this view, development consisted of and was promoted by diffusion and acculturation, and underdevelopment remained because of obstacles or resistance to this diffusion (Frank, 1969:48).

This notion of cultural diffusion or transference was well illustrated in Blouet's (1981) analysis of the development of education in Barbados during the emancipation period of the 1830s and 1840s. She demonstrated how the British attempted to transfer educational ideas and principles from England into the West Indian setting. The intent of the metropole to educate freed slaves was to ensure the economic welfare of the metropole and the local British elite, thus education for the masses was a mechanism of economic and social control. Blouet observed:

> Education was seen as invaluable for inculcating the ex-slaves with moral attitudes which in turn encouraged acceptance of the existing social and economic system (p. 223).

The thrust of British policies on her colonies was to disseminate "English moral and cultural values" (p. 231).

The failure of diffusion and assimilation to promote economic development and social change has been acknowledged by both the developed and developing nations. Carnoy (1974:134-141) in discussing the impact of educational policies of France and Britain on West Africa in the 1920s, contended that they were both "assimilationist" since they forced the African to learn in the context of an imported European education structure. In both systems, the existence of European colonialists in positions of power determined the aspirations of Africans in schools. Similarly, Clignet (1978) pointed out that before and after World War II the French government introduced into its colonies the same educational programs, curricula, and techniques as those used in French metropolitan institutions. He termed this strategy "assimilation," "where the colonizer stresses the universality of his own culture" (p. 135). Policies superimposed metropolitan structures and values on the colonized but their success depended on the degree to which the colonized adapted to them. It was a situation of unequal relationship as it did not take the perspectives of both parties into consideration.

It is clear that the centuries long contact and diffusion between the metropolitan countries and the developing nations failed to result in the economic development of the latter.

Frank (1969:21) criticized the modernization theory as "empirically invalid when confronted with reality, theoretically inadequate in terms of its own classical, social, scientific standards, and policy-wise ineffective for pursuing its supposed intentions of promoting the development of the underdeveloped countries. Many social scientists (Carnoy, 1974; Carty and Smith, 1981; Hoogvelt, 1984; Navarro, 1976) shared a similar view and further contended that modernization theory had no historical method and therefore no theory of social change.

Frank (1969:66) asserted that it was not so much diffusion which produced a change in the social structure as it was the transformation of the social structure which permitted effective diffusion. For him, development, underdevelopment, and diffusion were all a function of the social structure. Diffusion so far had produced development only for the few, and underdevelopment for the masses. Consequently, the structure of the system had to change in order to permit development for all the people. He thus argued for and advanced an alternative theory that addressed the history and contemporary reality of development and underdevelopment.

B. Dependency and Underdevelopment Theory

Within the last two or three decades the terms dependency, development, underdevelopment, colonialism, and neo-colonialism have dominated the study of economics, politics, and social change in Third World countries. However, in Canada, as well, as early as the 1920s and 1930s, Harold Adam Innis had pioneered a liberal version of dependency theory based on the notion of a "staples economy." He argued that in Canada energy was directed toward the production of staple commodities (for example, fish and furs), and that the importance of the metropolitan centers, such as Great Britain and Europe where luxury goods were in great demand, was crucial to the development of Canada (Innis, 1956:384-385). In the Third World, the "dependency and underdevelopment" theory had its origin in Latin America as they attempted to industrialize post World War II. It was first outlined by Paul Baran in the 1950s, and later popularized in grander fashion through the seminal work of Andre Gunder Frank in response to the modernization theory promulgated by the United States.

Baran's thesis was that the advanced capitalist countries had become developed by expropriating economic surplus from other overseas countries with which they traded and which they later colonized; while the overseas countries became underdeveloped by aiding the ascendancy of the West. This economic interaction left the overseas countries with a class structure, dominated by a small elite, whose economic interests were linked to those of the advanced capitalist nations, and whose lifestyle and tastes were an imitation of the same. This was the essence of the "dependence" (Hoogvelt, 1984:166). Frank (1969) expanded on this theme and advanced a theory of underdevelopment with the twin concept of "metropole-satellite" to characterize the nature of economic relations between the advanced capitalist nations with the developing countries.

He posited that these metropole-satellite contradictions exist not only internationally but nationally and locally. Thus, he asserted:

> a whole chain of constellations of metropoles and satellites relates all parts of the whole system from the metropolitan center in Europe or the United States to the farthest outpost in the Latin American countryside (Frank, 1969:6).

The ties of dominance and dependency thus run in chainlike fashion with the metropolitan states appropriating the surplus from the satellites, and so on down to the shopkeepers from the customers.

Dependency theory is seen as creating a framework in which to analyze economic, political, and social change in the dependent countries. It argues that historical time is not linear, and that it is impossible for the developing countries today to duplicate the process of change which took place in the developed nations in another historical period. It posits that many of the obstacles which impede development in developing countries are the result of the relationship which these societies have with the developed nations. The dependent relation between the periphery and the center is transmitted through the dominant group in the periphery. Consequently, it is argued that any lasting improvement in the human condition in the developing countries must be largely limited to the dominant group in the developing countries. This is the result of social, political, and economic relationships in the international capitalist system--a stratified social structure, political institutions necessary to maintain that social structure, and an economic system which is geared to meet the needs of a small elite. Moreover, such a structure creates a cultural alienation where the values and norms are copied or taken from the metropole rather than from local experience. Consequently, we find a cultural dependency occurring which includes dependency on technology, concepts, and art, thus limiting he developing of new forms of institutions (Carnoy, 1974:50-58).

The process of industrialization has created increasing dependency in the Third World countries on the metropole for financing, markets, technology, and capital goods, to name a few. The health care system as a major institution in the society would reflect such dependency. It can be expected that there would be certain groups, for example, public officials, politicians, physicians, entrepreneurs, who enjoy high incomes, social status, and political power. Directly and indirectly, they are dominated by and dependent upon special interest power groups (e.g., multinational corporations, World Bank, Canadian International Development Agency [CIDA], World Health Organization) in the metropolitan countries for investments, grants, and aid--technological, financial, and human. These groups play a major role in determining health care policies and programs in the developing nations. Nursing, as an integral part of the health care system, will of necessity be influenced by the concepts, values, and ideas of the donor nations. Moreover, this dependent relationship in the health care system and nursing education between the developing nations and the metropolitan countries is further transmitted through the dominant group in the developing countries. Since this group is generally educated in the western developed countries, their values, norms, and ideas reflect those of the metropolitan countries. There would be, consequently, a cultural and intellectual dependency in health care, nursing education, and nursing services.

C. Theories of Colonialism

Closely linked with the dependency theory are the theories of colonialism. One of the earliest proponents in the 1950s was Mannoni (1964) who put forth a psychological view of colonization. The colonial relationship, he posited, was derived from the previous psychological condition of the colonies and the colonized that is the need or drive among different kinds of people to dominate others or to be dominated. The relationship was a psychological one and the solution was individual intensive psychotherapy for both parties. Colonizer and colonized were prisoners of their past and more specifically of their childhood. Their interaction, therefore, followed patterns of development that were independent of the political and economic components of the colonial situation. For Mannoni, the colonial situation was an inescapable necessity, and as Clignet (1978: 126-128) pointed out should we believe him then there would be no room for social action.

Memmi (1967) and Fanon (1967) while divorcing themselves from Mannoni's extreme views, incorporated the psychological dimensions of his analysis and combined it with the political-economic aspects of the colonial relationship. Memmi (1967) in assessing the psychological and cultural impact of assimilation on the colonized person, observed:

> in order to be assimilated, it is not enough to leave one's group but one must enter another; now he [she] meets with the colonizer's rejection. All that the colonized has done to emulate the colonizer has met with disdain from the colonial masters (p. 124).

It is Memmi's thesis that assimilation was doomed to failure as assimilation and colonization were contradictory because of the reciprocal relationship between the colonizer and the colonized. He concluded "to say that the colonizer could or should accept assimilation and, hence, the colonized's emancipation, means to topple the colonial relationship" (p. 126). He thus focused on the condition of the colonizer and the colonized in the colonial situation. Firstly, the colonizer needed the poverty and degradation of the colonized to justify his own place in the society. Were it not for the colonized he would not have been able to do as well economically, since the colonial system exploits the colonized to the profit of the colonizer. Secondly, the colonial system manufactured colonialists, that is a colonizer who agreed to be a colonizer just as it did the colonized. The colonizer had the economic and political support of the metropole behind him whereas the colonized had no power. The colonized was not free to choose between being colonized or not. Moreover, all the institutions of society were shaped by the colonizer to fit his view of the colonized. Since the colonized was forced to function within those institutions he began to accept the colonizer's conception of him. It can be expected that the health care system would reflect a similar pattern. The British as the colonizers would have the power and control of both the nursing services and education of local nurses, and these institutions would be shaped by the values, ideas, knowledge, and skills of the dominant metropolitan country at the given time.

Carnoy (1974:63) pointed out that the relationship between Memmi's analysis and dependency theory was seen in the colonial relation which determined the pattern of development or non-development in a colonized country. The result of colonization was the condition of poverty without the responsibility for the condition in the hands of the colonized. The services produced were primarily to meet the needs of the colonizer. Memmi (1967) elaborated further as to the results of the colonial situation on the colonized:

> to subdue and exploit, the colonizer pushed the colonized out of the historical and social, cultural and technical current (p. 114).

This view was also supported by Altbach and Kelly (1978:5) in their analysis of educational development in colonial systems. They pointed out that colonial schools while they were detached from the colonized's societies and cultures, were similarly detached from the societies and cultures of the colonizers. "It represented a basic denial of the colonized's past and withheld from them tools to regain the future" (p. 15). They noted that the implications of this were enormous for what transpired in colonial education was a simultaneous obliteration of roots and the denial of the wherewithal to change except on limited terms.

Fanon (1967) had long before observed as well the effects of the colonial situation on the individual in his acclaimed book, **Black Skin, White Masks.** He portrayed vividly the assimilation process:

> Every colonized people--in other words, every people in whose soul an inferiority complex has been created by the death and burial of its local culture originality--finds itself face to face with the language of the civilizing national that is, with the culture of the mother country. The colonized is elevated above his jungle status in proportion to his adoption of the mother country and cultural standards (p. 18).

Fanon (1967) further extended his and Memmi's analysis to post-colonial colonialism. It was his argument that the transfer of power from the colonialists to the national elite maintained colonial institutions and often increased the economic and social power of the ex-colonial country. The national elite after independence acted as an intermediary (Carnoy, 1974:68). They attempted to take over where the Europeans left off but they did not have the wealth or power of their colonial counterpart. Fanon's comments are illustrative:

> The national middle class which takes over power at the end of the colonial regime is an underdeveloped middle class. It has practically no economic power, and in any case it is in no way commensurate with the bourgeoisie of the mother country which it hopes to replace. In its narcissism, the national middle class is easily convinced that it can advantageously replace the middle class of the mother country. But that same independence which literally drives it into a corner will give rise within its ranks to catastrophic reactions, and will oblige it to send out frenzied appeals for help to the former mother country (p. 189).

For Fanon (1967:245-246), turning over the reins of power to the local middle class by the metropolitan power did not create a national culture. This was so because the colonized retained their traditional practices which were the product of colonization, and the local elite adopted the culture of the metropole. Consequently, development only occurred within the constraints of the metropole culture, and was a continuation of the colonial model.

There is clearly much similarity between Fanon's interpretation of post-colonial colonialism and Frank's views of dependency theory discussed earlier. Altbach (1971) in a similar vein contended that neo-colonialism, which he described as "the impact of advanced nations on developing areas" (p. 543), was most evident in education. Educational neo-colonialism occurred through the influence of advanced countries on the educational policies and institutions of developing countries, and moreover, most developing countries had maintained the colonial pattern of school administration and curriculum thus retaining such of the orientation of colonial educators.

Similarly, nursing education administration and the nursing curriculum would retain much of the British colonial heritage. Fanon and Memmi's main contributions lay in their analysis of the colonial situation in underdeveloped countries. Memmi gave us the concept of the universal roles of colonizer and colonized. The former who either accepts his role as colonizer or who does not want to be a colonizer, and the colonized who accepts being colonized. Fanon went further by demonstrating how these colonial relations continued after a country gained independence. His significant contribution is that he showed how both traditional culture and the culture of the national elite were a product of colonialism. Moreover, what had been done by the colonizer could only be undone by the colonized (Carnoy, 1974:66).

Given these conditions inherent in colonialism and neo-colonialism outlined, nursing education policies and programs would reflect a combination of "local" values to be transformed through colonialism as well as the metropolitan values, that is, a distillation of British, American, and Canadian ideas and practices.

In summary, the theoretical framework for this study is derived from a perspective that subscribes to a view of development that falls under the broad tradition of dependency theory. The central thesis of this theory is that the Third World countries are economically dependent on the metropolitan countries. This creates a domination by the metropole of the economies of the developing nations through such factors as foreign investments, loans, trade, aid, technology, and so forth. This dominant-dependent relationship is perpetuated through the elites in the developing countries whose economic and ideological allegiance is to the metropole. This unequal relationship is reflected in all forms in the society--intellectual, cultural, social.

In both its theoretical understanding and practical application, this theory seems suited to analyzing the Caribbean situation. The issue of dependence is seen by a number of Caribbean economists as Lloyd Best (1975), Alister McIntyre (1971), Clive Thomas (1965), and educators such as Bacchus (1980) as the dominant feature of Caribbean economics and society. While it is arguably a stagnant thesis, yet as Blackman, economist and later Governor of the Central Bank of

Barbados, observed:

> To this day I believe that 'dependency theory' provides a useful **descriptive** analysis of underdevelopment in former colonies. Unfortunately, having developed a useful theory of underdevelopment the scholarship of the New World economists fell apart ... they omitted the next logical step - the development of an **operational** model of economic development. The stress is on 'operational.' By operational, I mean 'likely to succeed in real world conditions' (cited in Payne, 1984, p. 9).

Notwithstanding this perceived deficiency that Blackman alluded to, there are a number of economists like him who are working in the "real world" of government in an attempt to manage and moderate dependency. While the theory was adopted by these Caribbean economists, its interpretation has generally been less radical than their Latin American counterparts. Payne (1984:9) suggested that the paradigm of Caribbean dependency has been dissolved into West Indian societies without changing it, except perhaps for Grenada. While his observation can be seen as a valid criticism of West Indian societies, it can be convincingly argued, and later demonstrated, that the historical tradition of the British Caribbean has not been revolutionary despite attempts at radicalism in Guyana and Grenada, and changes have been slow to effect.

Hope (1979:266) made such an observation, that the dependency of the Caribbean economy on the metropole had undergone little structural change; that it remained passively responsive to metropolitan demand and metropolitan investment with a strong intersectoral dualism. There was a small highly capital-intensive non-agricultural sector existing side by side with a more traditional labor-intensive agricultural sector. Similarly, Bacchus (1981) in his analysis of the educational system in Guyana noted the effects of this economic dependency on the metropole and the lack of basic changes in the economic and social structures. He demonstrated that education failed to promote economic development because education was still seen as a means of escape from the agricultural sector to the small capital-intensive sector, with a perpetuation of the dual economy.

In the health care system it can be expected that dependency on the metropole would favor economic incentives in the highly capital-intensive industrial sector in the form of infrastructures such as large urban hospitals, and technological equipment, as opposed to the development of rural-based health clinics. Consequently, nursing education would be focused on the preparation for acute care settings in urban areas and less on the preparation for rural health care. Additionally, changes in the system of nursing education and practices would occur slowly.

Health care and nursing education would be dependent on the metropolitan countries economically, intellectually, and culturally. Specifically, such dependency would be expressed in health care and nursing education policies and programs through the ideas and values of the dominant countries, that is, Britain during the colonial era, and subsequently, the United States and Canada in the post-colonial era. Development theory in terms of dependency seems most appropriate to understand, describe, and analyze the development of nursing education in Trinidad and Tobago.

CHAPTER IV

THE CARIBBEAN CONTEXT

This chapter is divided into two sections. Section I provides a brief historical overview of the British West Indian Society. Section II explores in greater detail the Trinidad and Tobago setting placing emphasis on its political, economic, and social development from its discovery in 1498 to the 1980s. The emphasis in both sections is placed on major political changes and their relationship to the economic and social characteristics of the society.

SECTION I

THE WEST INDIES: A HISTORICAL PERSPECTIVE

A. Geographic Location

The West Indies, as defined here, form a chain of islands stretching from Jamaica on the western point of the northern Antillean range, through the groupings of the Leeward and Windward Islands, to Barbados, and Trinidad at the southern tip of the eastern archipelago, and are rounded off by the twin mainland territories of Belize (formerly British Honduras) and Guyana (formerly British Guiana) (Figure 1). Jamaica, on the one side, is the neighbour of Cuba, and

The Map of the Region (The West Indies), Source: "Peoples and Cultures of the Caribbean," ed. Michael M. Horowitz. ©1971 by Michael Horowitz, reproduced by permission of Doubleday & Company, Inc. in Caribbean History and Economics ed. R.M. Delson, 1981, has been removed because of the unavailability of copyright permission.

Trinidad, on the other side of Venezuela, are one thousand miles from each other. The position of the area in the great tradewind belt gave it pre-eminence in the era of the sailing ship, and after that, in the new commerce of Caribbean tourism (Lewis, 1968:15). But of greater significance is the fact that the West Indies are important for their strategic value to the United States relative to the defence of the Panama Canal. Its climate determined the early growth of the region as a sugar area, along with the concomitant features of the slave trade and the slave plantation society which, as a socio-economic system, developed its characteristic institutions and social forms.

From their discovery by Columbus during the fifteenth century, they have been the scene of perennial warfare, for over three centuries, between rival European colonizing powers eager to despoil them of their riches. The historical forces of colonization, slavery, the plantation system, sugar, and emancipation have shaped the West Indian society, but the impact of each particular force has been different in each island. Since Emancipation (1834) the region has become more a geographical expression due, in large part, to the legacy of its colonial history. Even though all the islands were English speaking, the avenue of communication during colonialism was between the individual island and London rather than between the territories themselves. This led to the development of a sense of separate identity within each island people, the absence of any real Pan-Caribbean consciousness and the political Balkanization of the area. At the same time, because of the massive forces at play over the area, they left a common historical experience and a common imprint upon the people (Lewis, 1968:47).

B. Values

A leading characteristic of Caribbean history is that the controlling attitudes and values of the society today have been shaped, to a great extent, by the white European influence. Its ethnic composition has been basically Negro with a large East Indian population in Guyana and Trinidad, but its social and political directions have been European. Lewis (1968:55), in writing about the Caribbean culture, maintained that European control meant exposure, not to its art, technology, and sciences, but to its less attractive attributes--its lust for adventure, its drive for expansion, its search for quick profits, and the racialist arrogance and pride of the European man who failed to apply the idea of equality--so much at the center of European liberalism--to the subject of the Caribbean peoples. The English in the West Indies created a local culture almost entirely derivative of the English values even though geographically remote from the ancestral sources. Bacchus (1980:21), as well, observed that some of the cultural elements of other groups were assimilated into the dominant European culture which resulted in a "creole culture."

C. The Role of Women

European women throughout the centuries were regarded as the property of men and had no legal rights or power. In the Caribbean, this equally held true as Negro women were first the property of their slave-owners and after emancipation, concubinage continued to be a way of life for a certain class of Caribbean women as it afforded economic and social advantages. Thompson (1980) writing of the Caribbean women during the colonial period observed that "In a neglected society, the Caribbean woman was a silent, neglected entity. Improvements and reforms rarely touched her life" (p. 200). Even so, women played a major role in the economic life of the region. They worked in a variety of roles as domestic workers, sales clerks, agricultural and professional workers such as nurses and teachers, and government clerks. As well in the homes, many were engaged in the care and support of large families and of their aged relatives. Thompson (1980:203) citing Smith, noted that in households headed by men a small proportion of other relatives, largely children of a deceased sister or brother, lived in those homes, but in households headed by women, there was a large proportion of grandchildren, nephews, and nieces. Moreover, women were expected to support or subsidize the support of all those residing with them. They thus had to combine household responsibility with income-earning activities while the extended family provided them with access to a source of child care (Massiah, 1983:57). Yet, the legal system was often the enemy of the poor colonial Caribbean woman who was humiliated when she sought aid through the courts for child support, as the law placed the burden of proof of paternity on the woman. Marriage thus occupied an ambiguous place among working-class couples. The woman felt that marriage should elevate her social status and that the economic aspects should be the man's responsibility, while the man felt that a wife was often an economic liability whereas a concubine was an asset; consequently, he was unwilling to consider marriage until he was sure she would continue to be his helpmate.

The East Indian woman enjoyed a status no less desirable than the Negro woman. She married at an early age, through parental arrangements, and settled down to having a large family. The extended family was also a norm, with the ideal of male dominance in the family strong and reinforced by religious beliefs and practices. The women did not take much part in life outside the home, but were a great influence in domestic and kinship matters within the family, and often carried the economic burdens of the family where husbands were irresponsible (Smith, 1980:131-133).

Among the middle class Negro or creole couples the situation was similar to their metropolitan counterparts where the woman was the homemaker and the man was the income-earner. A striking feature, however, in Caribbean society was that the working wife was frowned upon, as the situation was construed as an indicator of the inability and the unwillingness of the male to support his family, and was a blow to the ego of the Caribbean man. This concept that the man should take care of his family adversely affected the life of many Caribbean women as it contributed to their position of servitude (Thompson, 1980:203-204).

Field-Ridley spoke for the majority of Caribbean women when she declared:

> Let us remember that the woman in Guyana, black woman as she is, has the weight of two streams of history to oppress her. The common history of the Caribbean which robbed all black people ... of their dignity ... as well as the history of the women of the mother countries who certainly by the time the Caribbean claimed

> notice from the European nations had already been firmly placed in the kitchen and in the house to care for the children (cited in Thompson, 1980, p. 200).

Despite these social drawbacks, professional women made a major contribution to the society at great personal sacrifice, as it meant inhibiting their natural inclination by non-involvement in indigenous cultural activities. Rather, professional women were expected to be steeped in European culture, show a loss of appetite for native dishes, and even for a native spouse (Thompson, 1980:201). They tutored children, taught Sunday school, and acted as consultants in family and community affairs. In addition, they carried out the nurturing role of women--they loved, inspired, motivated, and helped children of the poor to achieve goals which were unattainable at that time.

Within the last two decades, governments have been attempting to focus on development programs for women. Despite the physical barriers to unity, women of the Caribbean have been attempting to bring about changes. The thrust towards Caribbean integration has been exemplified in a number of women's groups being formed such as the Caribbean Women's Association (CARIWA) with territorial chapters, Business and Professional Women's Clubs as well as a variety of forms of social development programs (Barrow, 1971). Barbados was the front runner in establishing a National Organization of Women in 1970 in its Health Department, and a Women and Development (WAND) unit in the Extramural Department of the University of the West Indies (UWI). Several Caribbean territories subsequently took steps to improve the status of women. Trinidad and Tobago established a National Commission on the Status of Women during International Women's Year (1975) which eventually became a permanent organization. It has initiated many projects in areas as family life, nutrition, and handicrafts, and has sought to effect changes in all spheres of the society to ensure improvement in the position of women in the society (Report on the Status of Women, 1976). Within recent years, women, for the first time in the history of the nation, have been elected to political positions. One interviewee, in observing the changing role and status of women, affirmed:

> Women are more assertive, more vocal, take a more active part in politics, and what is going on around them. Mrs. Norma Lewis, Minister in the Ministry of Health; Elmina Clark-Allen, Minister in Housing; Muriel Donowa-McDavidson in Community Development and Amoy Mohammed in Sports and Culture--won outright (Interview, January 13, 1986).

Most women are no longer at home. They are working and attending classes to enhance themselves. The 1980s find them occupying a wide spectrum of professional, academic, and technical positions in the post-colonial society.

D. Political Development

The political government of the West Indian territories was exercised through the instrumentality of the Crown Colony system. That system characterized West Indian political life from 1878 onwards. In the closing decades of the nineteenth century, British officials were looking for some way to reduce the mounting administrative costs and the embarrassment of small colonies which seemed economically unviable (Knight, 1978:208). Initiatives were proposed to forge political or administrative relations among the colonies--but they were fiercely resisted. It soon became evident that successful plans for centralized political arrangements in the Caribbean islands would have to be initiated by the West Indians themselves. By the turn of the century, West Indians had begun to indicate a degree of interest in the idea of political unity leading to a number of shared organizations. In 1919, a West Indian Court of Appeals covering the Leewards, Windwards, Trinidad and Tobago, Barbados, and British Guiana was established. That year, also, the need for scientific cooperation in agriculture led to the establishment of the Tropical College of Agriculture in Trinidad. Labor organizations, which emerged after 1920, took up the idea of West Indian social and political progress through political cooperation. This was one of the main themes of the West Indian Labour Congress held in British Guiana in 1926 (Lewis, 1981:56-57).

The deteriorating social and economic conditions of the West Indies during the 1930s led to widespread social and political unrest. Strikes and riots occurred in all the territories with the result that a Royal Commission of Enquiry was appointed to investigate the matter. Out of this milieu of disturbance arose local nationalist leaders who later played leadership roles in the establishment of the Federation of the West Indies in 1958. In a series of conferences between 1944 and 1958 the concept of political federation was brought to fruition. With British Guiana and British Honduras abstaining, Jamaica, the Leeward and Windward Islands, Barbados, Trinidad and Tobago became federated. The federation lasted four years--1958 to

1962. Knight (1978:204), commenting on the dissolution, asserted that "it was born in strife and rivalry over a number of issues, such as the geographical location of the capital, imposition of federal taxation, freedom of travel, a federal constitution, and a federal custom's union." Many reasons have been proffered for its demise. The weakness of the constitutional structure, the great distance between the islands, insular political squabbling among the politicians--Trinidad and Tobago favored a strong, centralized Federation with the Federal government playing an active and positive role in the integration of the national economy; Jamaica favored a decentralized system organized into a Confederation (Williams, 1981:xxv)--have been put forward as the main causes of the dissolution of the Federation. But the fundamental failure of the Federation stemmed from the conflict between competing forces of nationalism. Gooding (1981:71-72) and Knight (1978:205) have argued, in similar vein, that in the political evolution of the region two nationalisms have laid claim to the same territories. Nationalism at the grand federated level or West Indianism, which claimed the entire British West Indies to be one nation with a common past and future; and nationalism at the unit level or "islandism," which claimed the right to nationhood for particular island units. Suffice it to say that the insular economic interests of Jamaica and Trinidad took precedence over their sense of common identity with the result that Jamaica withdrew in 1961 followed by Trinidad, and the West Indian Federation collapsed in 1962.

With the rejection of "West Indianism" or nationalism at the federated level, the islands embarked upon the task of building free nations out of island colonies. Political independence in later years created the states in which Caribbean nationhood could develop, and economic necessities forced some common action. In 1965, Antigua, Barbados, and British Guiana (Guyana) signed an agreement to set up the Caribbean Free Trade Association (CARIFTA). The actual start of CARIFTA was delayed to allow the rest of the region to become members. The new CARIFTA agreement eventually came into effect on May 1, 1968 and British Honduras (Belize) became a member in 1971. The Caribbean Regional Secretariat was also established in 1968 and the Caribbean Development Bank (CDB) in October 1969. By 1973, CARIFTA was transformed into a common market - CARICOM (CARICOM, 1986). The economic problems in the Caribbean entailed not only increasing the gross national product or securing funds for projects and public administration but also the redistribution of resources within the countries. This has been the greatest challenge for the independent governments who have demonstrated a strong preference for English and American ideas and models and have deprecated the type of republican nationalism that has been common on mainland Latin America (Knight, 1978:203-210).

E. Economic Development

The contemporary scene in the Caribbean is one of superficial diversity but a great deal of commonality underlies this diversity. The most common and profound aspect of Caribbean life is a strong dependence on the outside world. The Commonwealth Caribbean depend on Britain, Canada, and the United States, and the trend is unlikely to cease in the immediate future because the economic situation, while not hopeless, cannot be termed encouraging (Knight, 1978:211). It has been posited that leaders seeking to promote necessary change must constantly ask "what models of the future are possible" (Gooding, 1981:222) and further that no ideology imported to the Caribbean would thrive without modification (Knight, 1978:212). Because the existence of the United States as a dominant power in the Caribbean area is an established fact of life, the Caribbean nations are enjoined to develop, concomitantly with policies of internal transformation, a foreign policy which would reflect subscription to broad democratic principles and the maintenance of friendly relations with the United States (Gooding, 1981:226). Yet, others take the opposite stance asserting that the challenge of the future will be to produce new and creative solutions to local problems, and that the circumstances of the Caribbean will force it to be a revolutionary society (Knight, 1978:212). To date, Guyana and Grenada have been the only two countries that have attempted to use a revolutionary pattern for reconstruction of the societies and in both instances their efforts were aborted through American intervention. Jamaica, in 1976, under Michael Manley's leadership broadened the Eurocentric model of social change to one of democratic socialism. Trinidad followed a pattern "less revolutionary and more gradualistic, and less totalitarian and more democratic than the Cuban path" (Williams, 1970:511). An understanding of how Trinidad and Tobago arrived at this development model and the resultant consequences, it is necessary to look from a historical perspective at the developments in the society from its early days since its discovery by Columbus to the present time.

SECTION II

TRINIDAD AND TOBAGO: THE SETTING

A. Geography, Population, and Early History

Trinidad and Tobago are two islands in the southernmost part of the Caribbean Sea that constitute an independent unitary state. Trinidad is separated from the South American continent by the Gulf of Paria. Its average length is about 69 miles, breadth about 54 miles, and its total area is 1,864 square miles (4,828 km2). The island of Tobago lies about 26 miles northeast of Trinidad. It is about 26 miles long, 7-1/2 miles at its greatest breadth, and has an area of 116 square miles (300 km2) (Figure 2). According to the 1984 census, the total population was 1,168,200 of which 42,100 resided in Tobago. Negroes constituted 40.8 percent of the population, East Indians (both Hindu and Moslem) 40.7 percent, whites 0.9 percent, others 0.8 percent, Chinese 0.5 percent, and mixed--the combinations are numerous--accounted for 16.3 percent. Trinidad's religious diversity is even more bewildering than its racial complexity. Roman Catholics constituted 33.6 percent, Anglicans 15 percent, Hindus 25 percent, Muslims 5.9 percent, Presbyterians 3.9 percent, and a host of other Christian and non-Christian sects 16.6 percent (Statistics, 1984).

Trinidad was first discovered by Columbus in 1498 and taken possession by him for the Crown of Spain. The island remained a Spanish possession for almost 300 years, though it was raided by the

The Map of Trinidad and Tobago Source: Bridget Brereton, _A History of Modern Trinidad 1783-1962_, London: Heinemann, 1981, has been removed because of the unavailability of copyright permission.

Dutch and the French in the seventeenth century, until it was surrendered to the British in 1797. During most of those centuries under Spanish rule the island was neglected. The Spanish had difficulty in populating the island, and in 1783 they encouraged foreigners of all nations to settle in Trinidad. The sole condition imposed being that they should be Roman Catholic. The result was a large influx of population which was augmented by French families with their slaves who were driven from the neighbouring islands and elsewhere by the French Revolution, and to this is due the French element in a Colony which never belonged to France (Annual Report, 1920-21). Early in the nineteenth century attempts were made to attract additional white settlers, and in 1802 Chinese immigration was introduced as a possible source of labor but it proved to be unsuccessful as many returned to China.

The original Amerindian population had been worked to death on the Spanish sugar plantations and African slaves were eventually brought in to replace them. In 1797, when the British took over the island they were reluctant to import more slaves from Africa to develop the island as a sugar colony because there was growing opposition to slavery, and acceptance in principle of the gradual abolition of the slave trade. The labor problem, after emancipation in 1834, led to the introduction of a period of "Apprenticeship" on the sugar plantations in order to compel workers to remain in the estates after the abolition of slavery. To further provide labor for the plantations, they introduced an entirely new population--East Indian immigrants--as indentured labor. This continued from 1845 to

1917 when the system of indentured immigration ended. Thus it was that the whole population pattern in Trinidad underwent a drastic change, as 143,939 East Indians were introduced into the island. This had undesirable social consequences because the indenture system created over the years a poorly paid group undercutting the wage levels of the non-agricultural working class who were primarily negroes. This engendered racial animosity between the two groups (Lewis, 1968:201).

Moreover, because the Indians worked on the sugar plantations which were located in the rural areas, they were separated geographically, residentially, and occupationally from the other major ethnic group--the negroes. Further to that, their religion, social organization in terms of caste, music, dress, and entire cultural system were East Indian which reinforced the separation from the wider community (Brereton, 1981:108-114). It was a community, as Brereton (1981:115) pointed out, "whose attitudes ranged from fear to contempt to indifference." The Indians reacted defensively becoming even more closely knit.

Tobago, also discovered by Columbus in 1498, was the subject of continual dispute between England, France, Spain, and Holland. Tobago was essentially a sugar colony. England acquired the island in 1802, and in 1889, the island was amalgamated with Trinidad while retaining its own legal and fiscal systems; in 1899, it became a ward of Trinidad, uniting with it to form one colony (Encyclopaedia Britannica, p. 711).

B. The Movement for Self-Government

By the end of the First World War three decisive changes had taken place in Trinidad. The first was the discovery of oil in commercial quantities in 1910. The second was the abolition of the indentured system of Indian labor based very largely on its opposition by the nationalist movement in India. The third change that came over Trinidad was the emergence of the working class movement led by a radical European planter of Corsican extraction, Captain Arthur Cipriani, who formed the Trinidad Labour Party with a program of socialism, in close communication with the British Labour Party (Williams, 1962:216-217).

These changes formed the background to an intensification of the demand for constitutional reform at the end of the war. The movement was West Indian in scope and not limited to Trinidad. The principal advocate of constitutional reform was the Trinidad Working Men's Association. The British government eventually sent out the Parliamentary Under-Secretary of State for the Colonies on a visit to the West Indies and British Guiana in 1921. His recommendations opposed responsible government for Trinidad and Tobago, and did not consider it likely for some time. He did, however, recommend a new Legislative Council of 26 members, seven of whom were to be elected. Thus in 1925, for the first time a limited number of people of Trinidad and Tobago had the right to elect a small proportion of their own representatives. It was the first election (with limited franchise) in Trinidad and Cipriani was elected. He was the only member who identified solely with labor and agitated for old age pensions, and minimum wages. He worked closely with the Indian leaders and thus brought into the labor movement a substantial section of the Indian working class, giving to the Trinidad movement for self-government an interracial solidarity (Williams, 1962: 216-225).

C. Social and Economic Unrest

In 1937, the Commission investigating disturbances in the colony found that the sugar production in Trinidad and Tobago had doubled in ten years, and that Trinidad had become the leading Empire producer of oil accounting for 62.8 percent of Empire production in 1936. Concurrent with thi~~s economic picture~~ was the deplorable economic and social conditions of the workers. The Indian population in particular was riddled with hookworm. The incidence of infestation was 79 percent to 80 percent. Malaria and hookworm were the causes of death and debility in workers produced by the unsatisfactory housing and unsanitary conditions which existed on the agricultural estates and the surrounding villages. Further, there was an explosive social situation arising out of the discontent of workers, Negroes and Indians, in both the sugar and oil industries who had no legitimate means of expressing their grievances. Widespread violence erupted originating with the oilfield workers led by a black, Uriah Butler, an emotional mass leader (Williams, 1962:230). While Butler was never able to mobilize mass support, he and his colleagues precipitated the rise of trade unions that proceeded to become independent forces of their own and they engineered the direct entry of the working class into colonial politics (Lewis, 1968:208).

As a prelude to basic change in the orientation of policy which was being planned for the Caribbean area, a West India Royal Commission under the Chairmanship of Lord Moyne was appointed in 1938. The Commission was unwilling to recommend full responsible government but it allowed that ultimately the policy objective should be the introduction of universal adult suffrage (Ryan, 1972:65).

D. American Values and the Rise of Nationalism

The period 1938-56 has been described by Lewis (1968:207) as "the nadir of Trinidadian life." The tone of political life was lowered by flagrant immorality, by political charlatans, and political adventurers. Moreover, the colonial system allowed only "a singularly emasculated form of public service via the nominating member system" (p. 211), so that many well-respected Trinidadians never had a chance to carry their powers to the peak of the machinery of government. There was, as well, the impact of the "American occupation" on the colony during the war years (1939-45). This was the result of an agreement in which Britain consented to lease areas in the West Indies as naval bases to the United States in exchange for fifty U.S. destroyers, and sites in Trinidad were chosen for major naval and air bases. The sites chosen were prime lands and there was much resentment by the local population, some of whom were forced to relocate and others who were denied access to beach areas. But more importantly than all of this was the tremendous socio-impact that the bases had on life in Trinidad. It created employment opportunities on a massive scale at wages higher than any known before in Trinidad. Living costs rose sharply, thousands abandoned the established industries, and a great deal of money circulated. It created a boom-time atmosphere in which prostitution and crime flourished, and gang conflict and violence increased. Further, the American presence demolished the myth of white superiority, as Trinidadians saw the white American troops perform manual labor and behave in a drunk and disorderly manner. Trinidadians were also impressed by the efficiency of the high-level technology that the Americans brought with them. This was evident in the excellent roads constructed on and around the location of bases (Brereton, 1981:177-191). The end result in Trinidad, ten to fifteen years later, was a rough blend of "British snobbery and American vulgarity" (Lewis, 1968:212) yet the American influence accustomed thousands of people to decent wages and modern labor conditions.

The post-war years saw the introduction of full adult franchise in 1946 and the first elections held under universal suffrage, the maturation of the trade movement, and the intensification of the movement for self-government and federation. 1955 saw the appearance on the scene of the first genuinely successful mass nationalist movement, under the leadership of Dr. Eric Williams, one of the West Indies' most distinguished and brilliant scholars. It was the People's National Movement (PNM) under his leadership that took Trinidad and Tobago to independence in 1962.

E. The Path to Independence and Its Aftermath

The PNM came into power in 1956 during an upswing in the economy which began in the mid-fifties. With constitutional changes from a quasi-ministerial system, self-government was achieved in 1956. The attainment of self-government heralded what was to be three decades of uninterrupted power held by one party, democratically elected, the People's National Movement (PNM). Headed by Dr. Williams, who dominated the political stage for two and a half decades, the party had mass appeal and its battle cry was "massa day done." There was to be emancipation of the black and East Indian masses from "massa" through a process of social and economic decolonization, with the active participation of the state in education, economics, social services, and other areas (Williams, 1981:210-216).

Ethnic Composition in the PNM

A high proportion of the top leadership positions of the Party was recruited from the black or colored intellectual middle class, and while the dynamism and revolutionary idealism of the PNM was challenging to those who were hungry for change, it was frightening to established elements in the society. Politically conservative Hindus, white settlers and businessmen, the Catholic Church, the old-time trade unions, and political leaders feared its powerful hold over the Negro masses and did their utmost to undermine its influence. From the outset, the Party strove valiantly to be true to its multi-racial ideal by choosing East Indian, Chinese, and European candidates, but the center of gravity remained the Negro professional class (Ryan, 1972:149-162). Despite accommodating gestures of the new government, the years that followed the elections of 1956 saw a new trend of political polarization: the PNM versus the traditional elite in alliance with old-guard politicians and Indian leaders. The result was heightened tensions between the politicians of the two major ethnic groups, and progress towards the achievement of an genuinely interracial community was rather uneven. Ryan (1972:363) posited that while little advance was made in the direction of integration of the two major ethnic groups, there existed a growing willingness among many to recognize and tolerate continuing pluralism, and to argue that economic and educational improvements rather than political mobilization would bring the ethnic groups closer together.

F. Public Administration

The economic picture during the period 1956-62 was one of growth for the nation. The initial major problem that the new government encountered was administrative. This was getting the public and the civil service to accept the principle that ultimate responsibility for policy-making belonged to ministries of government, and not to civil servants (Ryan, 1972:345). The government, therefore, in 1959 appointed a one-man enquiry--"The Lee Report"--into the organization, cost, role, and function of the Public Service. Subsequent to the implementation of many of its recommendations and the achievement of Independence, a Working Party was appointed in 1964, "to consider and report on the role and status of the Civil Service in the Age of

Independence" (thereafter called The Working Party). These two Reports demonstrated clearly the pivotal role envisaged for the Civil Service in the development of the nation.

The Civil Service

The Civil Service under the colonial system was known as The Colonial Service, the recruitment into which was controlled by the Secretary of State for the Colonies except for minor clerical positions. The loyalty of civil servants was to the Governor, as chief decision-maker, and to the Secretary of State who were responsible for the promotion, transfer, conditions of service, and more or less, the entire career of the civil servant. Senior officers were recruited from the United Kingdom, and the only hope for the local officer was to work in the service until he retired so that he could draw his pension because the Service offered no future to him. While the nation was a Crown Colony, it was not essential to employ persons trained in economics, finance, and all the institutions which were necessary for a self-governing country because the Secretary of State brought these experts from England; but as the country progressed to independence, it became absolutely necessary to recruit and train personnel to undertake the responsibilities charged upon the country. The Lee Report (1959) was persuasive; it advised that:

> "... a concentrated effort should immediately be made for the training and recruitment of suitably qualified West Indians whose loyalty will be to the country they are called upon to serve and not to the Secretary of State for the colonies whose political interests are related to the maintenance of his Colonial

> Service. The time has come for the building up of a Trinidad and Tobago Civil Service. By this it is not meant that foreign officers should not be given the opportunity to join the Trinidad and Tobago Civil Service" (p. 3).

With constitutional changes pending, the Lee Report (1959) presented proposals that "would take the country to full internal self-government within a Federation leading toward full independence" (p. 2). Salary scales were to be upgraded in order to attract the best qualified candidates, and conditions of service improved so that they equated those existing elsewhere. The intent of the new constitution was to make provision for a Public Service Commission to recommend to the government appointments to the Public Service. It was envisioned that the establishment of a Public Service Commission would keep public servants free from political influence and would eliminate, as far as was practicable, any patronage (1959:13). The thrust of Lee's Report was to institute changes in the Public Service that would promote a sense of national pride and national consciousness.

Attendant upon the Report many recommendations were implemented. Over the period all appointees to the top levels of administration were local. The bulk were mixed or fully Negro; very few were of Indian or European descent. For the most part, the new appointees were those who had been trained in England and Canada and were well-equipped to move into the technical levels of administration than were native whites who, hitherto, had little need to acquire such skills to advance themselves in the Public Service (Ryan, 1972:346). But making the civil service local did not bring with it the desired transformation in its functioning. The Working Party (1964:4) observed that "the sort of concepts of administration that typified the colonial system" still persisted. The long period of colonial government had determined a Civil Service organized from the top downward. They warned that it was wrong to slavishly copy or retain English institutions and systems without regard to Trinidad's peculiar circumstances.

Civil servants still saw their roles as assemblers of information to be channelled, in appropriate files, to the senior officers. A critical shortcoming was the slow growth of a national spirit and of a national approach to national problems. Education, in its broadest sense, was seen as a major instrument through which this could be achieved. The Working Party emphasized the important contribution that the Civil Service had to make towards the nation's social and economic goals. Their fervor was expressed in these terms:

> As one of the principal institutions of government concerned with "national" problems the Civil Service has, therefore, a special interest in, and responsibility for, the development of a national spirit .... There is urgent need for the development of a new sense of direction ... senior civil servants should take the lead in this ... theirs is the task to lead the way ... (pp. 23-24).

It was clear that despite the increased demands of Independence, the Civil Service carried on as it did in the past. The Working Party noted that the administrative machinery often found difficulty in adjusting to the changes necessitated by the country's new status. They observed:

> In particular, the processes of decision-making had evidently not yet become fully geared to cope with either the magnitude or the urgency of the problems which confronted the new nation.....

> Examples were brought to our notice of the difficulty frequently experienced in securing prompt and clear-cut decisions. In many cases, it had not been possible to obtain even an acknowledgement, either of the original communication or of the several subsequent requests for "an early reply" ... (p. 4).

The Report (1964:6) acknowledged the presence of psychological attitudes that were deeply rooted in the past. It was suggested that where effective authority and power formerly rested in the hands of expatriate officials the tendency inevitably developed for the hierarchy of local officers to become almost inflexible in its internal relationships. Any movement that appeared likely to disturb the basis of individual status and prestige was apt to be fiercely resisted, even at the expense of significant improvements in administrative efficiency. While this was deemed an understandable reaction to a situation of restricted mobility, it led to power struggles, and to the detriment of harmonious efficiency of the administration.

Shortly after the Working Party Report the government made efforts to deal with the problem of disorganization in the civil service. A bill was introduced to deal with the problems of reclassification, remuneration, and grievance machinery, and it was also established that merit and performance rather than seniority would be the criterion for advancement. A major aspect of the new bill was the procedure for bargaining between the Government and the Civil Service employees (Williams, 1962:184).

While many of the concerns were addressed by the bill there remained some areas of controversy. Salary problems still caused discontent and demoralization, and a major issue was the right to appeal decisions of the Public Service Commission on matters relating to appointments, promotions, dismissals, and discipline. Many proposals had been advanced for reforming the civil service but, as Ryan (1972:361) pointed out, administrative reform is never an easy task in any political system even with the most mature. Perhaps, Sir Geoffrey King, in his Report of 1957, summed it up best: "The political effects of introducing the Ministerial and Cabinet system were clearly foreseen and prepared for, but nothing like the same attention was given to preparing the administrative services for the new tasks which would fall upon it" (Hansard, 1959:740 cited in Ryan, 1972).

G. Development Plans

During the period 1957-73, the government prepared and implemented three Five-Year Development Plans. Each Plan had a different emphasis with the one building on the other. The common theme in all three was the issue of unemployment. The provision of more jobs was the goal of all development planning in the country.

The First Five-Year Development Plan, 1958-1962

This Plan was an attempt to deal with the economic problems the nation faced. The emphasis was on expanding the country's power and water supply, on improving road communications, health and education facilities, and on the development of industries to attract capital. Infrastructural elements were at the fore in this Plan. During this period in the economy, oil was the prime mover. The industry surged ahead and the dominant position of this sector in the whole economy was strengthened. Trinidad became a petroleum economy, dangerously dependent on oil for export earnings and for government revenues. Agriculture continued to make an important contribution to employment and export earnings. Sugar had recovered from the wartime crisis and the years following were years of expansion. There was amalgamation of estates and concentration of ownership in the hands of two giant sugar companies. By the time Trinidad gained Independence, its sugar industry was dominated by a single company owned by the British sugar combine, Tate and Lyle (Brereton, 1981:214-217).

Apart from sugar and oil, the manufacturing sector was a significant development. A program of industrialization by invitation --the Puerto Rican Model--began in the 1950s which resulted in the establishment of thirty-five industries (Ryan, 1972:384). Loans from the Colonial Development and Welfare Grants constituted only 3.3 percent of total expenditures in 1960, and the government explored the possibility of securing a World Bank loan to expand electricity throughout the islands.

The Chaguaramas Deal

It was during this period 1959-63 that the American lease of Chaguaramas base became the object of a heated political and national issue. There was reluctance on the part of the Americans and the British to renegotiate the bases agreement with the government. It was ruled out by a commission as the site for the Federal capital and the issue assumed greater proportions by the Trinidad government. It was seen as a cause celebre for nationalism. Chaguaramas was "the principal hydra-head of colonialism--the crux of West Indian Nationalism, the symbol of West Indian Independence" (Williams, 1969:4 cited in Ryan, 1972:212). A march on the United States Consulate in which thousands participated was a huge success. With massive public support behind Williams, the Colonial office and the Americans had no alternative but to come to honorable terms with the government. Broadly speaking, the United States agreed to release most of the land around the base, and the base area was to be used jointly by the United States and local defence and security forces. Total withdrawal was to be in 1977 contingent upon world tension. Further, there would be American participation in the improvement of the country's roads, airport, and railway facilities (Ryan, 1972:224-232). This deal signaled the entry of another powerful metropolitan power in the development of the nation.

The Second Five-Year Development Plan, 1964-1968

The aims of the Second Five-Year Plan (1964-1968) were the expansion of the infrastructure and community development. Importance was attached to the diversification of production in the country, to narrow the gap between the more modern sectors of the economy and the traditional sectors such as agriculture. Community development involved establishing centers which promoted the development of art and culture. Despite all the efforts to diversity output, the economy still remained a petroleum economy in the sense that its rhythm of development was determined by what happened to crude oil production (Third Five-Year Plan, 1968:11-24).

Oil production grew rapidly reaching a record of fifty-five million barrels in 1966 and there was major growth in Trinidad's refining capacity, geared to refine imported crude from Venezuela, the Middle East, and West Africa. Refining throughput increased from fifteen (15) million barrels in 1937 to one hundred and thirty-seven (137:2) million in 1965 (Brereton, 1981:214-215). The tremendous expansion in oil refinery at Pointe-a-Pierre and Point-Fortin, two ports at the south of the island, which involved large capital investments was accompanied by a tendency to concentrate ownership in the hands of a few major companies--Texaco, Shell, and BP. These three companies dominated the industry in the 1960s, producing 98 percent of the country's oil in 1965. It accounted for over 50 percent of exports and the island had become virtually a one-export economy. Between 1951 and 1964 the industry contributed about 30 percent of the Gross Domestic Product (GDP) and it was largely responsible for the steady growth of the GDP in those years. The heavy contribution of oil to government revenues helped to finance expenditures on public works and social services since the war, and the oil industry played a major role in developing a skilled labor force and a class of technicians. Because oil is heavily mechanized and capital intensive, the total labor force was small in comparison with other major sectors (Brereton, 1981:216).

The Third Five-Year Development Plan, 1969-1973

In the Third Five-Year Plan, the long-term strategy for the next decade and a half was to reduce considerably the extent of structural unemployment, to diversify the economy by increasing production in manufacturing, agricultural, and the tourist sectors of the economy, and to bring economic activities in the country under a greater measure of local control. Williams believed that the human, physical, and financial resources were not adequate for a full program of nationalization, and that some measure of dependence on metropolitan countries was inevitable (Ryan, 1972:390). Despite attempts to devise new economic strategies there was alienation of labor, capital, and vested interest groups. Increasingly strikes occurred and there was disenchantment with the government. The problem of unemployment rather than decreasing had become more acute. In 1956 unemployment stood at 6.5 percent of the work force, by 1970 it was 14 percent, with 60 percent among the youth (Jainarain, 1976:32-33). The standard of living, however, had generally improved. Per capita income had grown from $866 to $1,370 in 1971--among the highest in the developing world (Financial Times cited in Gooding, 1968:114).

During the implementation of the Plan, criticism by radicals and trade unionists was directed towards government's reformist strategy which they argued was not solving the country's economic problems. Moreover, the oil and sugar industries were accused of paying low wages to native workers, despite increases in productivity, while paying astronomical salaries to expatriate staff and making much profit. As noted earlier, the economy was dominated by three foreign firms. Oil and sugar accounted for 90 percent of the country's exports, and between 75 and 80 percent of all new manufacturing industry was dominated by foreigners. It was felt that the government's program strengthened the dominance of Anglo-American influences and that there were not efforts to create an ethnically integrated society based on popular participation, self-reliance, and social equality and cultural autonomy (Ryan, 1972:402-404).

H. The Continued Dominance of the Metropolitan Presence

By 1970, the development model used by the government while bringing more wealth into the land had in fact strengthened the position of "massa" socially and economically. There were now more foreign industries in Trinidad and the best positions in these were occupied by 77 percent foreign whites, local whites, and those of lighter-skinned, 10 percent mixed, 9 percent Indian, and 4 percent blacks. The local middle class had expanded and "adopted a style of life which was for the most part imitative of whites during the colonial era, a style which has had the effect, perhaps unintended, of excluding the bulk of the black masses from a meaningful share of the material wealth available in the society" (Ryan, 1972:370). With the exception of state-controlled services, local business in 1970 still followed hiring patterns carried over from the colonial period. There existed a correlation between race, color, and position, so that the best jobs were in the hands of whites, lighter-skinned blacks, and East Indians, with the lowest paid jobs and positions of least status group to the darker-skinned Indians and blacks.

Critics of Williams have blamed him for the failure of the government by 1970 to have come to grips with some of the main issues of social transformation, for the worsened conditions of the poor and unemployed, and for the resulting social unrest (Gooding, 1981:115-117). Gooding (1981) has argued, however, that Williams was determined to follow a middle path "in his effort to preserve a democratic system, maintain racial harmony, establish an acceptable level of stability, and concomitantly promote national development" (p. 118). Consequently, in pursuing this policy he sought to create an environment that would attract foreign investments from the United States and Europe, and moved to the right of the center path he had tried to follow. The government was committed to a program of change, but as the policies evolved, they took a path that involved state action but also one of cooperation with the free enterprise system which the government hoped to reform.

The "Black Power" Disturbances

In 1970, the youths, led by university students, the unemployed, the people from the slums, militants, and a number of left-wing groups joined together in a march outside the Royal Bank of Canada protesting Canadian racism (emanating from the issue at Sir George Williams University in Montreal, Canada where West Indian students were accused of smashing and burning the computer center) and economic exploitation. This progressed into anti-government demonstrations and marches against the entire social and political system. They proclaimed the theme of "Black Power" and "Power to the People." They denounced racial discrimination, especially in the employment and promotion practices of the business sector where, even in 1970, as was attested to earlier, it was still a truism that blacks were seldom employed in commercial banks and other private firms. They pointed to the high rates of unemployment, the urban slums, and rural neglect, side by side with wealthy residential areas (Craig, 1982:393).

The end result of these demonstrations was not only rioting but a military revolt of a section of the army. A state of emergency was declared and the revolt was eventually crushed. This traumatic experience marked a turning point for Williams and the PNM government. Williams was now forced to reappraise his government's economic policies and the Third Five-Year Development Plan. After fifteen years of development under the Puerto Rican model of industrialization, the main social and economic problems of the country had not changed or had worsened in some instances.

I. Perspectives for the New Society

A few months after the mini-revolution, the government published a document entitled "The Chaguaramas Declaration: Perspectives for the New Society" which became the principal guide to action in the 1970s and beyond. The emphasis was on economic independence and greater cultural autonomy. There was to be greater economic power for the historically dispossessed groups and greater popular participation in decisions affecting the community. Perspectives accepted the need for "revolutionary change" but insisted that this had to be guided by rational objectives and rational means (Ryan, 1972:451). The perspectives "reject[ed] both liberal capitalism (with its concomitant of penetration and take-over of the economy by multinational corporations) and the communist organization of the economy and the society" (Williams, 1981:49). In the "new perspectives" the government was to participate more actively in the industrialization program, and while foreign industries were not going to be turned away, they would have to accept direct partial control. Rural development was also to play a major role in helping to mobilize the population for national action, and the government increased its efforts to force private enterprise to adopt hiring and promotion policies based on qualifications rather than race, class or color (Gooding, 1981:142-155).

The economic programs initiated since 1970 had some impact. Thousands of jobs were created. With the upsurge in the economy due to the oil boom, the intent was "to use the additional revenue to accelerate the restructuring of the economy" (Williams, 1981:64). The fourfold increase in the price of oil in 1973 opened up opportunities for industrial development on government's own terms and by using local resources. The government embarked on a program of national reconstruction. It established an iron and steel complex, as the basis for future industrial development, which in the 1980s had expanded to include aluminum, fertilizer, petrochemicals, nitrogen, and a host of energy-based industries. Attention was also paid to developing local agricultural products to lessen the dependence on imported foods (Williams, 1981:81-100). Concurrent with the focus on economic issues, debates on constitutional reform were initiated in 1971 leading to a new constitution, and a final break of formal constitutional links with Britain in the declaration of a Republic in 1976, with an elected President as Head of State.

By 1980 the government's massive involvement in areas of the economy seemed to be paying off. Profits from petrol and other industries enabled the government to provide economic assistance to other islands in the region and to invest millions of dollars in education, health, and social welfare (Gooding, 1981:155).

Despite Trinidad's relatively good economic situation since Independence, loans were still necessary.

The Role of Aid and the Multi-National Corporations

One of the important responsibilities falling upon the government following Independence was the search for foreign aid. In this Trinidad and Tobago was at a disadvantage, for while it had a demonstrable need for aid, it also possessed a relatively high GNP per capita vis-a-vis other Third World Countries, thus rendering its claims for assistance much more difficult to sustain in the eyes of the "donor" countries (Williams, 1981:330).

Williams (1981:330) also was always concerned about the question of foreign interference facing the developing countries and, in particular, the steady, persistent, and increasing intrusion of such foreign pressures on the nation's domestic affairs. To that end, he claimed, although it was not an easy task, that the best guarantee of independence lay in the mobilization of domestic resources. The government recognized, nonetheless, that capital and technical help could be forthcoming through the Organization of American States (OAS) and, moreoever, Latin America represented a large potential market (Ryan, 1972:107). Trinidad joined OAS in 1967, and thus began a close association with the Inter-American Development Bank (IADB) in the country's economic and social development process during the seven-year period following the country's admission to the Bank. During that period, 1967-1974, the Bank made loans to finance projects in the sanitation sector, education, urban development, transportation, agriculture, and preinvestments. In addition to the financing for development projects, the IADB had provided funds for technical cooperation for the preparation of studies related to the country's development planning and project preparation efforts (PAHO/WHO, 1983). Since 1973, with the oil boom, Trinidad and Tobago no longer qualified. However, in 1986, negotiations were underway for IADB loans for renovations to three regional hospitals (Interview, January 21, 1986).

The World Bank had been another source for loans in 1971 when they contributed to the Population Project. Problems in securing loans occurred after the oil boom as Trinidad and Tobago did not qualify according to the conditions stipulated by the Bank.

The economy, at Independence, as discussed earlier, was dominated by multi-national corporations in oil and sugar. The regulation of these enterprises in the national interest was from the beginning a matter of great importance to the government, but it was equally a difficult and complex task to achieve. A major reason for this was to be found in the structure of these multi-national corporations, where the scope and scale of their activity, plus their internal accountability, was so great as to make them, in some instances, virtually "sovereign states." Consequently, they had to be approached with caution and handled with tact. This was particularly so in the oil industry where Trinidad and Tobago's position as a small producer and intermediate refiner circumscribed options quite severely. Policies had to be prudent yet flexible. The essence of the multi-national corporations was that it was tantamount to an international state within the boundaries of a national state, subject to a central direction and decision-making outside of the national boundaries. By 1978, the government had exercised its option in terms of national ownership and had holdings in industrial and commercial enterprises (Williams, 1981:340). Apart from the main bilateral donors, international organizations, such as World Health (WHO) and CIDA, offered technical assistance.

Creating a National Identity

Underlying all economic development was the government's desire to create a national identity. Education, both formal and non-formal, was seen as critical in fashioning such an identity.

Under the PNM government there had been a number of changes in the education system. From its inception to the time of Independence, the education system in Trinidad was divided between the overlapping and, at times, conflicting jurisdictions of Church and State. The denominational system was the prevailing structure. With the coming of Independence, education was seen as integral to the process of decolonization and as a means of promoting nationalism. There had formerly been no national outlook in education, no unified control, and the secondary school bore no relationship to the primary school. Moreover, the former was limited to only those who were successful in the common entrance examination. Additionally, the curriculum was metropolitan in scope, orientation and character--designed to prepare the students for metropolitan examinations and the metropolitan university system (Williams, 1981:239-250).

In 1965, amid vehement Catholic opposition the entire school system including the curricula came under close government control. There was a greater degree of centralization and while the denominational character was maintained, children of all faiths attended all schools regardless of the religious character of that school. Williams (1981:247) saw the government secondary school as the principal agency for the integration of the young population of the nation with its mix of every race and religious persuasion.

Since 1960 the government had embarked on a school construction plan. 1960 heralded the first group of free Secondary Modern Schools to be erected in the territory. These schools provided the opportunity for educating students beyond the primary level who would not have had the opportunity to do so before. A total of 2,900 additional secondary school places were provided that year--2,000 by government and 900 by the denominational bodies (Report of the Premier, 1962).

In 1967 a fifteen-year Education Plan was planned and embarked upon. Among its many objectives were the elimination of the Common Entrance Examination in 15 years, the introduction of junior secondary schools, and the double shift system to cope with numbers. It stressed the need to give greater emphasis to vocational, technical-

and agricultural training in the education of students (Williams, 1981:249-250).

The Plan was not without its critics. It was argued that it was more concerned with school places than with changing the basic nature of the educational system to make it more appropriate to the social and economic needs of the community; and, that little had been done to subsidize the production of material for the proper teaching of Caribbean history, even though it was made a part of the curriculum. Additionally, not much had been done about the teaching of Indian and African culture, history, and politics, and the content of the program had remained essentially British (Ryan, 1972:339-340). Notwithstanding these criticisms, some of which had been addressed in the 1970s, educational opportunity had been widened to all parts of the nation and was equalized to a considerable extent.

As previously indicated, the Trinidadian society was multi-racial with two major ethnic groups--Negroes and East Indians. Miscegenation over the years created a large mixed population. A major characteristic of the society, however, was the pervasiveness of the influence of the European culture which was seen in dress, language, and values (Bacchus, 1980:21-22).

In terms of occupation, traditionally the Negro in the urban areas tended to be educated for the civil service and the professions, while the East Indians tended to lead a family-bound and thrifty life, own their own business and work in the rural areas, saving to send their children to Canada or England to study (Hawkins, 1976:68-75). Since Independence, an increasing number of young, educated Indians were challenging the traditional Negro dominance in the professions of law and medicine and the civil service.

Added to the complex racial and cultural issues was the all-embracing influence of North America in all spheres of daily living. This influence inhibited progress toward any local racial or cultural unity. The many imports from the United States, the constant flow of tourists from the United States and Canada, and of Trinidadians up north, the many expatriates working in the area, and most of all, the continuous bombarding of the people with American radio and television programs induced them to live, eat, and think "American." These all prevented a radical shift in attitudes and values for a truly "national" or Trinidadian person to evolve (Hawkins, 1976:70-72). Williams (1981:259) recognized the importance of the role of the media in shaping national values and consciousness. He observed that there was no educational content in radio and television and that "foreign capital ... bring leftovers from Europe and America to impose on a gullible and unsuspecting population." By 1969, in the government's plan for national reconstruction, they had assumed 100 percent ownership in the major radio station and 90 percent ownership on the island's only television network (Williams, 1981:172).

Additionally, various strategies were used to encourage and promote indigenous cultural activities such as the steel band and arts, crafts, dance, and theatre. The Prime Minister's Best Village Trophy Competition crossed racial lines, and youths in the rural areas dominated the action. The folk arts and dances provided opportunity for each major cultural group to identify and project its [illegible] culture of Africa and India, and facilitated a fusing of East Indian and African folk dances and songs (Elder, 1972:80-84). Further, national and religious holidays were proclaimed.

Notwithstanding all these efforts, Ryan (1972) affirmed that colonial attitudes and structures had remained entrenched even though a nationalist government had been in power fifteen years. He described it this way, and it still holds true, to a large extent, in 1986:

> "... these (colonial) values and patterns of behaviour continue to bedevil the administrative system, influence educational and economic policy, and circumscribe achievement in the area of race relations" (p. 498).

The significance of the social, political, economic, and cultural events described in this chapter in the Caribbean and Trinidadian societies cannot be sufficiently underscored. Because of the smallness in size of these societies there is a wider active spread of family and friendship ties than would obtain in Europe or North America. Smith (1980) suggested that because of their small size "ties of friendship, kinship, neighborhood and clique membership cross and recross each other many times binding everyone into an elaborate system of reciprocal obligation" (pp. 133-134). Consequently, in such societies, there is an absence of privacy and anonymity. Any event or change, political, social or economic, introduced in the society touches the life of someone one knows, and the issue becomes a matter of public debate and discourse by every man, woman, and child. Calypsoes (local songs), in particular, provide the socially acceptable medium for putting forth a commentary, negative or positive, on such issues.

Understandably then, nursing and nursing education will be affected by events in the larger society of which it is an integral part. Landauer (1970) expressed it well when, in discussing recent developments in nursing education in the British Caribbean, she stated:

> If I have described at some length the political, socio-economic and health service trends in the area, it is because nursing as a social institution and a prime partner in the health business cannot be viewed or discussed in isolation. In the Caribbean, as elsewhere, if the role of professional nursing is changing, the change in brought about as a result of or in association with other and perhaps more profound changes (p. 176).

Summary

An overview of the political, economic, and social factors, including the role and status of women in the British Caribbean society, from 1498 to the 1980s, was highlighted with emphasis on Trinidad. The significance of the impact on these societies, and particularly Trinidad, of the British values and traditions in the colonial era and after, was described. Of equal importance was the deliberate action taken by the government of Trinidad, since self-government in 1956, to turn to North America for technical aid and loans while attempting to build a national identity and become self-reliant. The culmination of these activities and the ensuing social struggles resulted in a society that was an amalgam of British, North

American, and indigenous features. This background provided the context in which health care and nursing care were delivered and nursing education evolved and developed.

CHAPTER V

THE COLONIAL ERA: LAYING THE FOUNDATION

A. Establishing Health Policies

The earliest recording of health and medical services was 1814 when a proclamation was issued enacting:

> ... that a certain Board called The Medical Board should be established in the manner therein mentioned and that for the preventing of the indiscriminate introduction and admission of persons to practise Medicine and Surgery in the said Colony, and also to prevent the sale of Medicines and Drugs of bad quality, or the sale of any sort of Medicines or Drugs by any persons not duly authorized or qualified in that respect, all persons who should practise Medicine or Surgery in the Colony or who should vend any Medicines or Drugs without such licence as in therein mentioned should be liable to the penalties therein in that behalf respectively provided (Julien Report, p. 2).

Subsequent to this proclamation, several ordinances were passed between the years 1832-96 which dealt with the health and medical services of the Colony. Among these were ordinances conferring power on the Governor:

i) In 1833, "for the establishment of a Board of Health to prevent the introduction or spreading of the Disease called The Cholera";

ii) In 1840, "to establish and provide for the maintenance of a Public Hospital";

iii) In 1890, "to establish whenever required, general and district hospitals for the relief of the sick poor, special hospitals for sick children, and lying-in women of the pauper class, hospitals and asylums for the special care and treatment of persons suffering from mental disease, or persons affected with leprosy, or persons attacked by an infectious or contagious disease requiring the segregation of the sufferers, and alm houses, or houses of refuge for the imbecile, aged, infirm or destitute poor" (Julien, 1957:3-4); and

iv) The appointment of a Surgeon General and District Medical Officers in 1869 and 1870 respectively.

The first hospital, the Colonial Hospital, was constructed in Port-of-Spain in 1857 and formally opened in 1858 with a nursing staff of a Head Nurse and eight other nurses and a small core of medical staff. The second hospital was opened in San Fernando in 1860. The nurses were unqualified and untrained and were reputed to be the descendants of the midwives who were selected as far back as 1826, when proprietors were worried over the fear of financial loss as well as the loss of their slaves due to childbirth, that they made representation to the Governor to take steps "to improve the class of women acting as midwives both among free women as well as the slaves." Very little teaching or training in the art of nursing took place and the nurses were under the direct supervision of the doctors who taught them how to do dressings and make poultices which, at that time, was the extent of treatment available to hospitalized patients. The qualifications necessary to become a nurse were that she could read and write and was of good health and character (Waterman, 1975:14).

As early as 1870, when the first expatriate Surgeon General was appointed there was a concern for the provision of health services in the Colony. From its beginning, the health services, in particular the hospitals, were designed first and foremost for the European settlers, and secondarily for the local people dependent on their social status. The East Indian population, who worked as indentured labor, were looked after by medical practitioners hired by the estate owners; but this arrangement was not in the best interests of the Indian immigrants as the doctors were employees of the planters. By 1875, a comprehensive scheme was designed in an attempt to provide better medical attendance on indentured immigrants, medical aid to the poor, and to establish a medical service to the Colony (Seheult, 1946:41-42).

In 1892, public health was of concern because of the plethora of illnesses brought about by the tropical climate and less than desirable living conditions which existed; therefore, legislation was passed "for the Better Protection of Public Health." Curative medicine, however, symbolised in the growth and elaboration of hospitals and dispensaries, held first place everywhere. By 1896, it was feared that yaws was becoming an epidemic with the result that legislation with respect to its treatment came into force. The ordinance provided for the establishment of dispensaries in the affected districts and for the compulsory attendance of patients (Annual Report, 1896:19). Thus, by 1899, four smaller hospitals were constructed in Trinidad and Tobago (which was now a ward of the colony) for the treatment of yaws which was considered an insidious but curable disease, as well as a segregation hospital for infectious diseases (Annual Report, 1899).

Meanwhile, bed capacity had increased in the two larger hospitals with the patients with leprosy and yaws, and maternity cases. This caused attention to be directed again to the training of midwives. The Governor appealed to the Medical Board which was the registering body for doctors and druggists for help in the matter. Consequently by 1898, the Medical Board Ordinance provided for persons who could read and write to be licensed as midwives after compulsory attendance upon ten cases of labor, and under supervision in the hospital for not less than three months with an oral examination (Ord. #1, 1898, Chap. 12).

B. Genesis of Nurses' Training

The first record of nurses' training was in 1898 when an English trained nurse was appointed Superintendent of the Colonial Hospital, Port-of-Spain, in order "to instruct the pupil nurses." At that time, the first local trained nurse, Barbados-born Eleanor Roberts, was sent to St. Thomas Hospital, London, for a period of training (Fields, n.d.). This was Florence Nightingale's training school for nurses which was founded in 1860 and was an established success. Its reputation was renowned by the 1870s, and candidates were accepted from different parts of the world with the understanding that they would model her pattern of training nurses in their own countries (Allemang, 1974:2). Eleanor Roberts is reputed to have "had the good fortune" of having met Florence Nightingale during her stay in England (Fields, n.d.). On Roberts' return in 1901, she was appointed Superintendent of the Colonial Hospital, Port-of-Spain.

The Port-of-Spain Hospital started with a bed capacity of 200 and by 1900 the bed capacity had increased to 320. Because of the notable increase in surgery, and consequently surgical nursing, it became evident that skilled nurses were needed. The government decided "in the interest of greater efficiency to engage the services of a fully trained nurse and midwife from England, in order that she should instruct the nurses and raise the standard of nursing" (Waterman, 1975:14). It was not, however, until 1908 that the first fully trained English nurse and midwife was appointed Matron. She was joined by a number of other English nurses who assumed administrative positions, but the training of nurses which had been in operation for over half a century was far from satisfactory and measures were taken to bring it up to "modern" standards. In 1913, a curriculum was prepared on lines used in English hospital schools of nursing. The program of study was three years:

> 1. Pupil Nurses (1st Year). Course of twelve lectures on elements of nursing, to include elementary physiology and anatomy, by the matron, and six demonstrations on ward work by the assistant matron.
>
> 2. Junior Probationers (2nd Year). From May to September, a course of twelve lectures on surgical and ward work, by the Matron, six lectures on drugs--their properties and dosage--by the medical staff. From October to February, twelve lectures to include advanced physiology by the medical staff.
>
> 3. Senior Probationers (3rd Year). From May to September twelve lectures to include advanced anatomy, by the medical staff. October to February twelve lectures on medical nursing by the matron and six lectures on gynaecological nursing and care of infants by the assistant matron (Waterman, 1975:14).

At the end of each course, an examination was held. This pattern of training continued for several years with greater care taken in the selection of candidates.

The training of midwives was also addressed. The training period was increased to six months and a written as well as an oral examination was conducted (Williams-Cook, 1975:32). The fact that nurses and midwives were trained side by side for many years is attributed to the idea, which became a practice until the 1960s, that a nurse must also become a midwife. The decades of the 20s and 30s saw a number of different English matrons in charge of the hospitals, with a gradual deterioration in nurses' training. Probationers worked for six months without salary to determine their suitability to nursing. They worked long hours, 12 hours a day, with no time off for the first six months. Later on they were permitted two hour breaks. After the first year an allowance of $4.00 per month was given and meals, laundry, a room, and uniforms were provided. After this period, they did two and a half years with midwifery included in the third year. On graduation they became trained nurses (Interview, March 11, 1986).

At that time, nursing drew its recruits primarily from the lower and middle class with education at primary schooling as only the upper class could afford secondary schooling. As late as 1945 secondary education was still the preserve of the few; although opportunities were eventually made for girls to have access through fee-paying intermediate and private schools which led to the school certificate examination (Reddock, 1984:217-229). The ethnic group was predominantly negro or negro extraction, and a few mixed. East

Indians did not enter nursing until the 1960s. With the expansion of free secondary education into remote areas, and the breakdown of traditional and religious Hindu customs such as early and arranged marriages, East Indian women began choosing careers and becoming a part of the workforce (Interview, January 17, 1986).

In the health field, malaria, gastroenteritis, and pneumonia were major causes of death, tuberculosis was widespread, and nutritional deficiencies were evident (Annual Reports, 1931 and 1936). These caused medical and nursing services to become strained with expansion of beds to accommodate those patients at the hospitals, thus making greater demands on the nursing staff. Moreover, the educational standards of applicants were far below standards required. Consequently, in 1935 a special board consisting of representatives of the Directors of Education and Health was appointed to examine all applicants for admission. The need for revision of the whole training of nurses began to receive attention (Waterman, 1975:15).

C. Emergence of a Nurses' Association

Despite the problems in their working conditions and their training program, the nurses in the 1930s were visionary. In June 1930, the trained nurses in the south of the island, San Fernando, banded together to form the South Certificated Nurses Association with the following objective:

> ... to foster the study and advancement of general nursing and midwifery and subjects pertaining to the nursing profession(s); (sic)

> To promote and maintain an esprit-de-corps among members of the profession(s); and to raise the standard of general nursing in Trinidad and Tobago ... (TTRNA, n.d.:17).

As early as 1931, the issue of state registration for nurses was raised at one of the monthly meetings. By March 1932, the Port-of-Spain Trained Nurses Association was inaugurated, and later it included midwives to become the Port-of-Spain Trained Nurses and Midwives Association (Fields, n.d.). Both the northern and southern associations were active in making representations to the local authorities as well as to the several committees and Royal Commissions that conducted enquiries into matters affecting nursing. They worked vigorously at promoting state registration for nurses. Much guidance and assistance was given to them by members of the medical profession, particularly Dr. J.A. Waterman, in the preparatory work towards nurse registration (Waterman, 1975:15). It was not, however, until 1946 after exhaustive negotiations that they combined forces to become the Trained Nurses and Midwives Association of Trinidad and Tobago with a northern and a southern branch (TTRNA, n.d.). This was a significant event as it heralded an era of combined efforts on plans and programs which formerly were fragmented.

The Association was instrumental in providing scholarships in 1944 and 1945 for local nurses to continue their education in public health at the West Indies School of Public Health in Jamaica which triggered government subsequently to offer scholarships for post-graduate studies. It intensified pressure for the granting of state registration, made representations to the Royal College of Nursing in England to set up post-basic courses to meet the special needs of the local nurses; started refresher courses and published a Nurses Journal. It also provided a counselling and advisory service (TRINCAS) for the profession (TTRNA, n.d.). These are but a few of the accomplishments of the Association.

It was not content to focus only on the continuing education needs of members. Pre-nursing scholarships were offered to enable girls to bridge the gap between leaving school at 16 and entry to training at 18 years. This period was a time when girls of desired standards of education and suitability were lost to other professions. The contribution of the Association to nursing education cannot be underestimated. It worked hard at improving the status of nursing. It is because of those nurses' vision, dedication, fortitude, and perseverance that the Nursing Council of Trinidad and Tobago came into being in 1950, and that the Association was admitted to full membership in the International Council of Nurses (ICN) in 1953.

D. Commissions and Enquiries into the Health Services

The Medical and Nursing Services were developed from the British Overseas Services and later, the Colonial Services, where applicants were recruited to serve in the colonies. From its inception the Health Services were a cause of constant concern, and difficulty was experienced in recruiting medical officers for colonial service due to the terrible conditions which prevailed in the health services. As early at 1907, a Commission of Enquiry was appointed to investigate "certain allegations against his [the Surgeon General's] administration of the Medical Department" (Seheult, 1946:45). This was the first of what was to be the beginning of a number of investigations which continued unabatedly for subsequent decades. In 1933, the Medical Reorganization Committee was appointed "to consider the general organization of the medical service of the colony and to advise on what steps would be taken to improve it." They made 40 recommendations. Among them were: an increase in the number of doctors and nurses, the extensive expansion and reconstruction of hospitals and hospital facilities throughout the colony, and the provision of hostel accommodation for nurses (Julien, 1957).

There is no record that any of the recommendations were implemented, and by 1937 a Commission (under the chairmanship of Mr. John Foster) was appointed by the Secretary of State for the Colonies as a result of disturbances in the Colony. Its mandate was "to inquire into and report upon the origin and character of the recent disturbances in the Colony of Trinidad and Tobago and all matters relating thereto, to consider the adequacy of the steps taken to deal with these disturbances, and to make recommendations" (p. 13). Of the many recommendations, five of them related to medical and health services and, in particular, focused on public health. In 1938, outbreaks of violence in the British West Indies provoked the appointment of another Royal Commission under the chairmanship of Lord Moyne, "to investigate social and economic conditions in Barbados, British Guiana, British Honduras, Jamaica, the Leeward Islands, Trinidad and Tobago, and the Windward Islands and matters connected therewith and to make recommendations (West India Report, 1945:xiii). They expressed disquiet about the high infant mortality and the prevalence of chronic sickness in the islands, the tendency to neglect the rural in favor of the urban, and the concentration on the cure of disease instead of on its prevention. Seven of their recommendations dealt with public health; among them were the training of nurses, the partial reorganization of the medical services, the formulation of long-term health policies, and the appointment of a Medical Advisor to advise on health policies stressing preventive medicine (West India Report, 1945: 434-436).

The urgent need for a long-term medical and health policy for Trinidad and Tobago was underscored by the recommendations of the Moyne and Foster Commissions. Yet the majority of these recommendations were either not implemented, cast aside, or replaced by others without regard to public opinion or public requirements. The expatriate Medical Advisor, two and a half years after the Report, still saw it fit to appoint a non-West Indian to the post of Medical Officer at the Colonial Hospital, Port-of-Spain despite recommendations to the contrary. With tuberculosis rampant on the island, it took almost eight years before an expert was sent to adviser on the situation. Hospitals continued to be under-staffed, under-equipped, and under fire from public, press, and the profession. Yet the repeated demands for an enquiry into the administration of the Medical Department remained unsatisfied De Verteuil, 1943:111-117).

The malnutrition and chronic sickness in the people generally was made worse by the exclusively metropolitan character of the medical education which emphasized curative rather than preventive medicine, with the result that there was bitter resentment against the medical profession. Because of the nature of the colonial service, the technical officer's status was lower than that of the administrative official. Any expenditures required the latter's approval with the result that funds in areas related to tropical medicine were pitiably small. The indigenous people, therefore, suffered the most from this administrative conservatism. Consequently they turned to the obeah man or the "waterpeople" medium or the "bush-doctor" for the help they could not get from officialdom (Lewis, 1968:87). Traditional healing practices were consequently reinforced because of this indifference and inability of western medicine to cure the particular illness. Thus, many of the indigenous people combined traditional healing practices with metropolitan medical practices, and the latter became often the last resort when all else failed.

The war was considered by the then-expatriate Medical Advisor as a major factor contributing to the acute shortage of medical personnel and the reason proferred for delaying the Royal Commission's urgent recommendation for the unification of the West Indian Medical Services. The current unsatisfactory conditions that prevailed in the health services were virtually ignored. De Verteuil (1943) argued:

> ... The causes for this shortage go much further back than the war period, and it has long been recognized that the terms and conditions of service in all the West Indian Islands including Trinidad, have been very unsatisfactory to the extent that the British Medical Journal considered it necessary some years ago to warn intending applicants against accepting some of these appointments.
>
> ... In the face of these facts it would appear that the Medical Advisor has been attempting to put the cart before the horse, and in so doing is actually clogging not one but all four wheels of West Indian progress and unification; and it would not be surprising if we are faced with more resignations, and a still more acute shortage of Medical Officers if the unification of the Medical Services is still further delayed ..." (p. 116).

The formation of a Medical Policy Committee was proposed with the public health recommendations of the Royal Commission's Report as a basis for discussion. The immediate development of some Health Centers as models was seen as a priority. These Centers were envisioned as not merely for paupers but for the well-being, improvement of health and health conditions for all members of the community. But the colonial pattern of Health Administration was in full swing in the 1930s with Directors of Medical Services and Senior Medical Officers invariably drawn from expatriates, usually after retirement from the Indian or African Services. They operated under standardized rules, laid down in London, which provided a set line of action to cover every conceivable situation. Following the era of the retired expatriates came the early local appointees to these "top posts." They were selected largely because of their propensity for towing the line--the London line. Many of them were deemed more colonial in mentality than the expatriates whom they succeeded. Initiative on the part of a young officer was a liability in those days, categorized as insubordination, and severely crushed. A favorite form of punishment was a banishment to a backwoods post (Comissiong, 1970:40).

By 1944, yet another Committee (The Russell Committee) was appointed by the Acting Governor, with similar terms of reference to previous committees. This Committee carried out a detailed examination of the medical and health services of the colony and made several recommendations. It found, among other things, grossr deficiency in the medical staff with no real effort being made to build it up; grave shortage of nurses; an absence of esprit de corps and loyalty; deficiencies of apparatus and equipment; poor quality of nursing staff due to the absence of a thorough and comprehensive basic training; tendency to stress the curative side to the detriment of the preventive side; and dissatisfaction among junior medical officers with the conditions of service. Nursing recruitment came in for severe criticism. They noted:

> ... that much evidence was given in support of the contention that most of the local candidates now offering themselves for the nursing profession lack the desirable social background and the necessary standard of education. To this was attributed the incompetence, the brusque manner, and the lack of sympathy with human suffering which has formed the subject of numerous complaints. It cannot be too strongly emphasized that the success and failure of a hospital depends, in great measure, on the quality of its nursing staff. Hence every effort should be made to attract the right type of young women to the profession .... On the other hand, the nurses complained of inadequate salaries, the lack of quarters, the long hours of duty, the low esteem in which the nursing profession is held locally, the lack of facilities for advanced training, and the consequent inability of locally-trained nurses to attain the highest posts (Council paper 6506, 1944; Rec. 15 and 16 cited in Julien, 1957:79).

They further commented:

> ... From all of the foregoing any policy which may have been formulated would appear to have been of a short term nature ... the rebuilding of the ... colonial hospital, long overdue, is only now under active consideration and there are no proposals for the rebuilding of the nurses' quarters ... which are all disgracefully inadequate. While we make every allowance for the difficulties arising from war conditions, we feel nevertheless that there has been undue and unexplained delay in carrying out these obvious and urgent requirements as regards medical and public needs (Council paper 6506, 1944; cited in Julien, 1957:5).

The government of the day was in general agreement with the recommendations but decided on account of the cost involved to regard the program of capital works to be undertaken as a long-term project in light of the financial position of the Colony (Julien, 1957:5). The immediate post-war period was marked by a continuation of building construction and advances in therapy and technique. It was also a time of growing administrative problems and growing service inadequacies and the pace of reorganization remained slow and ineffective to meet the fast-growing problems (Chan, 1975:23). Several committees continued to be appointed either by the Governor or the Secretary of State for the Colonies. The Tuberculosis Hospital, nurses' training, poliomyelitis epidemic, and a Health Insurance Scheme were topics of investigation. Constitutional changes which were taking place since 1940 led to the introduction of a ministerial system in 1950 when the responsibility for Health Services was removed from a Director of Medical Services to a Minister of Health.

E. Struggles to Attain Local Leadership

The West India Royal Commission Report (1945) had acknowledged the absence of local nurses in senior positions in the nursing services, but made it abundantly clear that the training of nurses had to be improved, particularly in the smaller countries. It was put this way:

> ... until more attention is given to training, the claims of the majority of local nurses to promotion cannot be entertained and their very natural dissatisfaction at the slowness of their progress to responsible positions must remain ... (p. 160).

It recommended the appointment of Sister Tutors and the institution of scholarships to enable nurses to take post-graduate training overseas, as well as the centralization of training facilities to facilitate better instruction. It was just at that time, 1938, that the first Sister Tutor (unqualified) from the Overseas Nursing Service was appointed to the Port-of-Spain Hospital, and a revised syllabus and program of training was started in 1943. The training period was increased to four years as "there was a high incidence of tuberculosis" (Interview, January 10, 1986) and the extra time was seen as beneficial to enable students to gain more knowledge (Bryce-Boodoo, 1975:33). The syllabus consisted of:

Year I:	Hygiene and First Aid
Year II:	Anatomy and Physiology
Year III:	Surgery and Surgical Nursing
Year IV:	Medicine and Medical Nursing

Students went from the wards to the classroom for lectures and some practical demonstrations, while the Ward Sisters and senior nurses taught them clinical nursing on the wards. The hospitals conducted the examination and awarded certificates; and midwifery was undertaken in the fifth year with an examination by the Medical Board. This latter qualification was compulsory before an individual could be considered for a staff nurse position (Foster, n.d.).

The 40s and 50s saw initial concrete steps taken to improve nursing education. In 1943, the Rushcliffe Committee was appointed to examine both the training of British nurses for service in the Colonies and the training of indigenous nurses. This Report (1945) advocated local training with standards that would enable reciprocity with state registration in Great Britain. It was expressed in these terms:

> ... in order to assist the attainment of the aims which we believe should guide nursing policy in the Colonies, all trained nurses should be registered and that the control of such registration of nursing education and of the discipline of the profession in each territory or group of territories should be in the hands of a Nursing Council set up under a Nurses' Registration Ordinance. A Midwives' Council should, similarly, be established under a Midwives' Registration Ordinance ... (p. 9).

The need for post-registration training overseas, the introduction of the "block"* system of training, and at least one qualified and experienced Sister Tutor in training schools were among some of the major recommendations. Further constitutional changes occurring during these decades, the recommendations of various reports (Russell, 1944; Rushcliffe, 1945; West India, 1945) and repeated requests by the professional association constrained government to provide a series of scholarships. Consequently by 1945, four student nurses were awarded scholarships to pursue training in the United Kingdom. This was followed by scholarships for post-graduate training when six Ward Sisters were selected for one-year courses at the Royal College of Nursing and selected hospitals (Bryce-Boodoo, 1975:33).

Subsequently, those who could have afforded it financially pursued training abroad. This practice, however, was not beneficial to the country as many did not return on completion of their studies. To compound the situation, because of the shortage of nurses in Britain both during and after World War II, the General Nursing Council's entrance examinations in Britain were abolished which led to an open door. A Selections Committee was established in the Department of Health by the Colonial Office to facilitate pre-selection and interviewing of candidates who wanted to go to Britain for training. This caused a further drain on local human resources (Interview, January 31, 1986). Meanwhile, attempts were being made to improve conditions locally for student nurses. In 1945, two Sister Tutors were appointed by the Colonial Office, one for each teaching hospital, and a new nurses' hostel with classrooms was built to ensure that students were comfortable and their studies facilitated. Gradually, there was the beginning of the appointment of local persons to administrative and teaching positions. In 1945, the first Trinidad-born, U.K. educated nurse, Anne Lumsden, was appointed Sister Tutor to the Colonial Hospital, San Fernando. A new leaf in nursing education was turned, for it was the first time in Trinidad that a Sister Tutor was not on contract to the Colonial Office. The following year, 1947, saw a Tobago-born, Trinidad-trained nurse, Pearl Maynard Ottley, appointed as the first local Matron to the Colonial Hospital, Tobago (Fields, n.d.). That same year, 1947, Emily MacManus, Matron of Guy's Hospital, London, and Blanche Shenton, visited the Colony on assignment from the Colonial Office in order to report on the following:

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* This is a system where nursing students had continuous classroom lectures for a given period of time, e.g., one or two months, without clinical practice at that time.

> the organization, training, and registration of those engaged in nursing the sick in the British West Indian territories ... the adequacy of the curricula and staff for Nursing and Midwifery training with special reference to practical instruction and to teaching on the preventive aspect of Nursing, the adequacy of the facilities for training Nurses in these territories with special reference to the Health Services ... and to make recommendations (MacManus, 1947, cited in Dolly, n.d.).

Their report dealt at length with poor conditions, facilities for training, and the need for better training. Unlike other commissions of enquiry there was no written support for the assumption of ultimate responsibility by local nurses. Notwithstanding this, MacManus gave much encouragement, inspiration, and assistance to the nurses at the numerous meetings held on her visit to the island, and was an invaluable help in discussing the proposed law for registration of nurses (Interview, January 31, 1986).

By 1949, with the advent of the two Sister Tutors a few years prior, and attendant upon the Rushcliffe and MacManus Reports, the nursing curriculum was revised. A Preliminary Training School was started, the block system was introduced, and student nurses were allowed more classroom experience through these changes. The revisions followed this pattern:

> (1) A Preliminary Training System in which the student spent three months in orientation and basic subjects and the minimum few hours of practical ward experience;
>
> (2) Along with the training block study of another one or two months, regular lectures were received;
>
> (3) In 1951, small groups of students were sent to the Sanatorium at Caura to obtain three months' training in Tuberculosis nursing ... (Bryce-Boodoo, 1975:33).

During the 1950s, there was great difficulty in obtaining qualified Sister Tutors from Britain in sufficient numbers or for long periods. A major thrust spearheaded by the professional association was to have locally prepared nurses trained as Tutors. Many local nurses were not sent abroad, and the reason proffered was that they generally did not have the required educational preparation for entry into Sister Tutor courses. Berenice Dolly, a former President of both the professional association and the Nursing Council and a respected nursing leader, stated:

> ... there was some of that [educational preparation] but it was not adequate, so we fought this and had special courses run by the Association with the Extra-Mural Department of the University of the West Indies for tutors ... I myself went to the Royal College of Nursing in Britain and requested them to send the tests here, and that I would supervise them rather than have nurses go all the way to Britain and perhaps not qualify (Interview, January 31, 1986).

Science courses, identified as a weakness in the general education of girls at that time, were eventually offered by the Extra-Mural Department of UWI for prospective tutors. Some of the first tutors came out of this upgrading program which facilitated their entry into post-graduate programs abroad (Interview, January 31, 1986).

On June 2, 1950, the Bill for Registration of Nurses was proclaimed and the Nursing Council of Trinidad and Tobago came into being--a milestone in the history of nursing and nursing education in Trinidad and Tobago. For this major accomplishment, much credit must be given to the Nurses' Association, which kept on undaunted in its pursuit of obtaining nurse registration. The Council assumed responsibility for the syllabus and the examinations for nursing education--functions which were performed by the hospitals for many decades.

By 1952, the Council had embarked on a number of activities. A recruitment campaign was started with the aim of attracting suitable candidates for nursing. Letters were written to the Heads of Schools requesting their cooperation, and both the press and radio were involved in promoting the drive (Fields, n.d.). The Council also had drafted the requirements for examinations and determined the length of training for admission to the Register. The program was shortened to three and one-half years, 12 weeks of which were spent in the Preliminary Training School. There, the students received lectures in Anatomy and Physiology, Hygiene, First Aid, Ethics, and Nursing. One and one-half hours were spent daily in practical work in the classroom, while visits were paid to the various departments such as sterilizing rooms, laundry, and the kitchen. Short visits of one hour's duration were also spent on the wards under supervision. At the end of the 12-week period, an examination set by the Training School was taken. This was followed by a period of one month on the wards so that the student's adaptability for patient care could be assessed. Entry to the hospital as a student nurse was then permitted to those successful thus far. Preliminary examinations were held twice a year in May and November. These were conducted by doctors and senior nursing personnel and consisted of three parts--written, oral, and practical. The final examinations were also held twice yearly in May and November with physicians, surgeons, and senior nursing personnel as examiners. The examinations followed the following format:

I. Preliminary Examination

    (a) Written Examination

        Hygiene, First Aid - 2 hours

        Anatomy and Physiology - 2 hours

        Theory of Nursing - 2 hours

    (b) Oral Examination

        Five minutes on each of the above subjects

(c) Practical Examination

A few days later a Practical Examination was held for 20 minutes with senior nursing personnel as examiners.

II. Final Examination

(a) Written Examination

Medical Nursing including Materia Medica - 2 hours

Surgical Nursing including Gynaecology - 2 hours

General Nursing including Dietetics - 2 hours

Two physicians and two surgeons conducted an oral examination of each student.

(b) Practical Examination

This was held some days later in a simulated situation, covering 20 minutes for each candidate, with senior nursing personnel as examiners.

The first nursing examinations by the Council were held in November 1951, and yet another new page in the history of nursing education was turned (Beckles, 1985:2-3). This, however, did not mean the end of the problems of the training programs. Although the pass mark was 50 percent, 64 percent passed in 1951 and 51 percent in 1952. There was thus evidence to suggest that the Council's standard of examination and the ability of the students to cope needed considerable adjustment (Beckles, 1985:3).

In 1953, M. Houghton, Education Officer to the General Nursing Council for England and Wales, was appointed by the Secretary of State for the Colonies to visit and report on the various hospitals in the British Caribbean Territories and to make recommendations for the improvement of nursing training. The recommendations called for an increase in the number of Sister Tutors in the hospitals, the appointment of a Nursing Officer to assist the hospitals with advice on training and allied matters, the necessity for post-graduate and refresher courses within the Caribbean area, and the need to attract girls of good background and education to the Training School (Houghton, 1953 cited in Julien, 1957:6). Despite the efforts of the local nurses to improve standards through the Nursing Council, there were two serious obstacles to the full recognition by the General Nursing Council for England and Wales of the training given in Trinidad. These were:

> (1) The lack of sufficient tutorial staff for the number of student nurses in training [and]
>
> (2) The overcrowding in some of the wards which was not only undesirable from the point of view of the patient's comfort and welfare but made it difficult for the nursing staff to teach and to maintain good nursing standards (Houghton, 1953, cited in Julien, 1957:90).

Following this report, in 1954, Lucy Fields was the first Trinidad-trained nurse to be sent to the U.K. on a government scholarship to take the Sister Tutor's course at the University of Edinburgh, and in 1955 she was subsequently appointed to the position of Senior Sister Tutor at the Colonial Hospital, Port-of-Spain, the first Trinidad-trained nurse to hold such a position. When she assumed that position, she gave a new dimension to nurse education as her experience in Public Health and Tuberculosis nursing in London was of assistance to the Nursing Council in giving public health and hygiene a prominent place in the syllabus and examinations (Interview, January 31, 1986). Concurrently, in nursing service the first ward sisters were appointed to the post of departmental supervisors and the subsequent decline in numbers recruited from overseas to fill these posts. Nursing education and nursing service were finally beginning to provide their own indigenous leadership.

Summary

During the colonial period the provision of health services in the colony from 1814 to 1956 was a cause of continuing concern. The early establishment of health care services and nursing care was designed primarily for the expatriates, and the leadership in the medical and nursing services were recruited from the British Overseas Colonial Services. Consequently, the focus was on curative care while public health received scant attention. The deplorable economic and social conditions in the 1930s, in which there were high infant mortality rates, tuberculosis, and chronic illness rampant among the plantation and oilfield workers, resulted in social uprisings and a shortage of medical personnel. As a result, the health services became the subject of a series of Commissions of Enquiries into prevailing conditions over the years. It was within this environment that the foundations of a British apprenticeship system of nursing education was laid. But recommendations from the various Enquiries were slow to be implemented by the expatriate senior medical personnel leading to resentment by local medical and nursing staff. Unity of action symbolized in the formation of a local nurses and midwives organization created the impetus to effect changes in the nursing program, and facilitated the development of indigenous leaders and the growth of the profession, through the accomplishments of Registration of nurses and the formation of a Nursing Council.

CHAPTER VI

THE POST-COLONIAL ERA: BUILDING FOR THE FUTURE

This chapter is divided into five sections. The first section deals with the earliest action taken since self-government by the newly-formed government that was directly concerned with nursing and nursing education. The second section outlines the vision of the government with regard to health through its three Development Plans, its First National Health Plan, and its health priorities for the decade beyond. The third section describes the significant nursing events which occurred regionally and their effects on nursing education nationally. The fourth and fifth sections recount initiatives taken by the local nursing leadership in nursing education.

Nationally, there has been a blurring of responsibility for nursing education between four principal agencies--the Nursing Council, the Nursing Division (Ministry of Health), the Hospitals, and the Nursing Schools. While each has played a major role in the education of students, there have been conflicts arising out of their overlapping responsibilities. The focus on the fourth and fifth sections will be on the Nursing Council and the Nursing Division respectively, as they exerted the greatest influence on nursing education, the former, through its regulatory mechanisms and the latter, as the apex of nursing leadership in the Ministry of Health and for the nation.

While hospitals have provided the major setting for clinical practice for students, these facilities have been the subject of a number of enquiries over the years and have already been addressed. Consequently, they will be considered only peripherally within the context of the examination of the Nursing Council and the Nursing Division.

With regard to the Schools of Nursing, the Principal had the responsibility for the administration of the program. This included planning the theoretical content and selecting appropriate learning experiences for students. The teaching staff comprised Nursing and Clinical Instructors; the former have all been prepared in institutions of higher education; and the latter have been prepared in formal clinical instructor programs in Britain or in local continuing education programs. The Nursing Instructors were responsible for teaching the nursing courses and some support courses while the Clinical Instructors supervised students in the clinical areas in addition to the ward staff. Further, arrangements were made with a number of non-nursing personnel, such as physicians, surgeons, sociologists, social workers, pharmacists, and psychologists, who teach on a part-time basis (Curriculum, 1982:1). The School, however, was often caught between hospital needs and the statutory regulations of the Nursing Council. Moreover, there was a dual line of reportability for the Principal of the School. In the hospital, the Matron was the titular Head of the School of Nursing, and the Principal reported to the Matron in a line relationship. Additionally, the Principal liaised with the Director of Nursing Education, Ministry of Health in theory, but in practice there was more of a line relationship. Consequently, the schools of nursing, like the hospitals, will be considered, where appropriate, within the context of the examination of the two focal sources of influence.

Figure 3 depicts the official organizational structure of the Schools of Nursing.

A. The New Government Takes Action

The Julien Commission

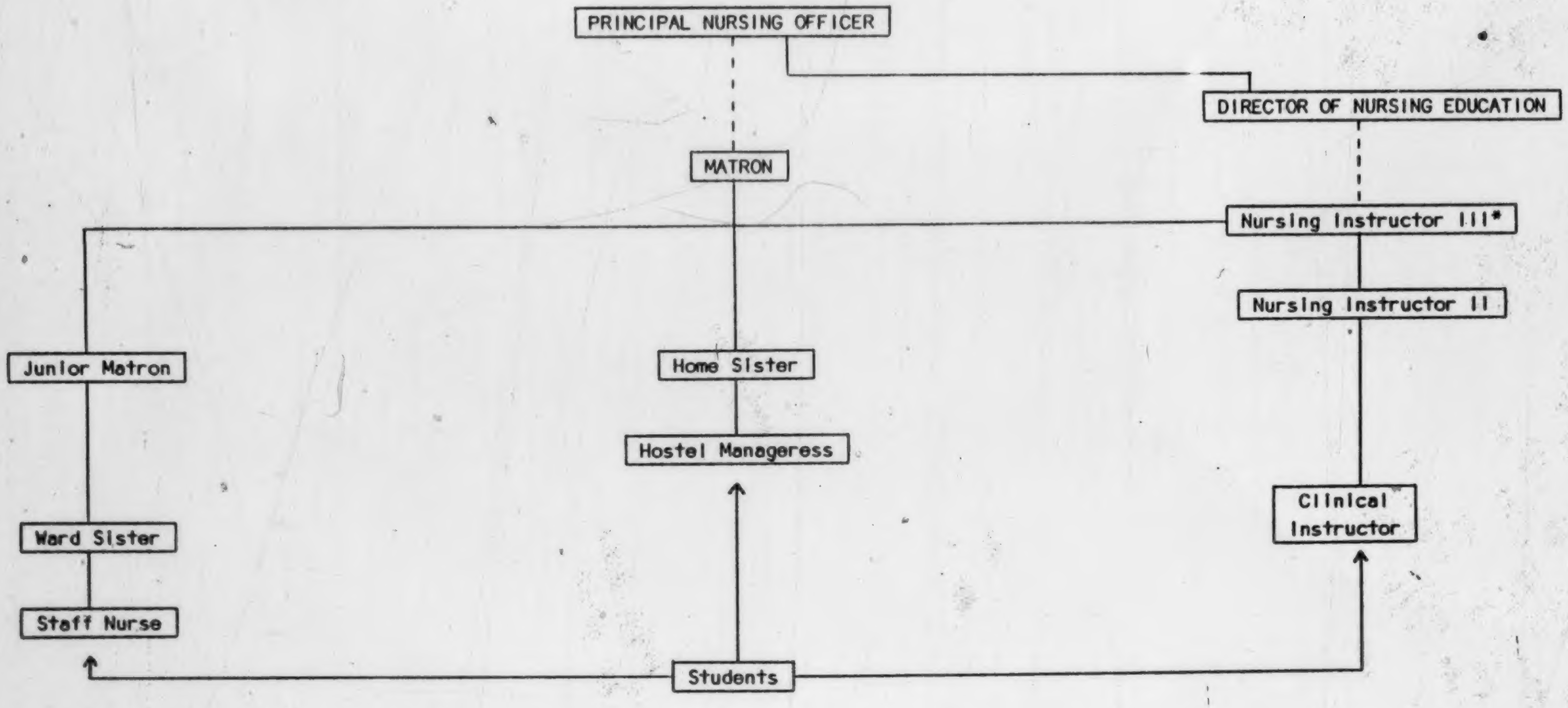
With the coming of self-government, the problems of dissatisfaction among staff and the public with conditions in the Health Services evidenced in the colonial era persisted. This resulted in the appointment by the government of a Commission of Enquiry on March 28, 1957, with the following terms of reference:

> to survey Hospital facilities in the Colony, to examine the causes and consequences of dissatisfaction with conditions obtaining at government Hospitals, among doctors, nurses, and all other grades of staff, particularly among the general public, and to propose remedies and make recommendations for improvement in respect of these matters (p. 1).

The Commission was thorough and exhaustive in its deliberations. Forty-seven meetings were held across the nation and visits were conducted to the three Colonial hospitals, the several district hospitals, health centers, and clinics throughout Trinidad and Tobago. In spite of the tremendous expansion of the medical and health services over the years, no proportionate development had taken place in administration and organization. Moreover, there had been no

Figure 3

Organizational Structure of Schools of Nursing


PRINCIPAL NURSING OFFICER
DIRECTOR OF NURSING EDUCATION
MATRON
Nursing Instructor III*
Nursing Instructor II
Junior Matron
Home Sister
Hostel Manageress
Ward Sister
Clinical Instructor
Staff Nurse
Students

Supporting Staff
Library Asst. I
Clerk I
Clerk Typist I

* Principal of the School of Nursing
SOURCE: Curriculum For Schools of Nursing in the Republic of Trinidad and Tobago, 1982

corresponding increase in staff, accommodation or in the provision of equipment. The Commission commented on the issue of shortage and, in particular, as it related to nurses and their training. It was expressed candidly in these terms:

> ... There are shortages everywhere. There is a shortage of doctors and nurses; a shortage of accommodation for patients, doctors, and nurses; a shortage of supplies; a shortage of drugs .... The chief causes of their [nurses] shortage may be found to be due to the inadequacy of their training both before and after they go to the wards, the very strenuous and long hours of work which they have to endure, the unsatisfactory conditions of service, and the inadequacy of salaries and allowances paid to certain grades of nurses ... (p 12.).

Failure in the Nurses' Preliminary School Examination was attributed to the scarcity of qualified Sister Tutors, and the inability of Ward Sisters to find time to teach nurses as much as they should because of the serious overcrowding on the wards and the acute shortage of staff. The refusal to give a student nurse a third opportunity at passing the examination was also seen as contributing to the shortage (Julien Commission, 1957:55).

The area of discipline was equally a contentious issue, as the only machinery for the enforcement of discipline in the Medical and Health Services was the normal Civil Service procedure which was considered rather dilatory and circuitous. The Commission was harsh when it commented:

> we fail to see how such a disciplinary medium, pregnant as it is with dilatoriness, could ever run efficiently an organization like the Medical and Health Service where promptness of decision, quickness of dispatch, and up to date efficiency often makes the difference between life and death (p. 14).

Their recommendations relative to nurses were far-reaching extending from the selection of candidates to their education, training, and conditions of service. The recommendations included the following: (1) the need for more trained, tutorial staff, permanently attached to the department and systematic post-graduate education conducted locally for nurses; (2) the availability of more post-graduate scholarships abroad for nurses in the service; (3) a more representative committee for the selection of students; (4) lengthening the Preliminary Training School course, and providing free uniforms, books, accommodation, and a small personal allowance for students; (5) an increase in salaries of registered nurses and an increase in the intake of student nurses for the next four to five years with corresponding teaching facilities; (6) raising the standard of selected students to prevent loss from the Preliminary Training School; (7) improvement in living conditions and an investigation into the use of Nursing Assistants similar to the system used in England and Wales; and (8) reorganization of the Nursing Services to include a Director of Nursing Services with an Assistant Chief Nursing Officer and an Education Committee (Julien Commission, 1957:55).

There were also recommendations related to policy-making in health care. A Statutory Board of Government with lay and professional representation was to be created as the policy-making body on health matters. The Board would have the mandate to establish a Disciplinary Committee with specific regulations. The principle advocated by the Commission was the transfer of the control of health services from the Civil Service to this Board with greater lay representation, as well as an integration of the Public Health and Curative Sections of the

Health Services. In order to cure the many defects which were found in the system, a reorientation of the entire medical and health services was proposed. This implied a change in administration, in policy, and in organization to ensure a greater measure of delegated responsibility and authority, and an enforcement of discipline. They noted that these changes would be of little avail "unless there is a change of heart and a change of atmosphere in our hospitals and other allied institutions" (p. 11).

Policy-Making in Nursing Education

Meanwhile, in nursing education, attention was focused on similar concerns--manpower needs and the basic preparation of nurses. Even before the Commission was appointed, an initial attempt to consider long-range planning and policy-making relative to nursing, was evidenced in a memorandum, dated 26 October 1956 sent to Lucy Fields, Sister Tutor at the Colonial Hospital from Dr. Gillette, Director of Medical Services. It stated:

> The formation of a comprehensive policy in Nursing Education aimed at producing trained nursing staff necessary to meet the several needs of the medical institutions of the Colony is being considered. The Director of Medical Services would appreciate the benefit of the view of the Senior Officers primarily concerned before finalizing his proposals.

Shortly after this memorandum, an Education Committee was formed by Dr. Gillette to formulate such a policy. Several meetings of the Committee were held over the next year and sub-committees were formed to address specific areas of concern. The minutes of the meeting, 15

March 1957, indicated that the task of the Sub-committee on Propaganda was to publicize the nursing profession so as to promote and enhance the image of nursing. In order to attract more and suitable candidates, a brochure was developed and four radio talks were prepared. The Mental Hospital Sub-committee, in examining the needs of that institution, projected into the future about the possibility of registration with the Nursing Council. Consequently, it advised that mental nurses should be trained in general nursing with a post-graduate course in psychiatry but that this should not be a pre-requisite to mental nursing. Further, the period of training--four years--be common to all nurses with the mental nurses taking the same preliminary examination as the general nurses after 18 months training, and that hostel accommodation be provided for female students.

At a subsequent meeting of the Education Committee on 22 March 1957, the Director of Curative Services, Dr. Comissiong, read an extract from the Nursing Mirror of 23 November 1956, which advocated the training of the State Enrolled Assistant Nurse as a member of the health team in order to keep pace with the demands at that time in England. He proposed similar action in Trinidad. Many arguments were put forward to convince the nursing personnel on the committee of the validity of the proposal. It was pointed out that whilst the standard of the fully trained nurse was increased, the rate of recruitment automatically decreased, and in order to make up the shortage trained Assistant Nurses could be used. The Chairman, Dr. Gillette, added another dimension. Since Trinidad nursing aimed at reciprocity with the United Kingdom, they were advised to adopt a similar course of action. No decision, however, was taken at that meeting. On 2 April 1957, a meeting of the committee was held "to investigate the desirability of instituting a system of training of Assistant Nurses in Trinidad on lines of training of this category of staff in the U.K."

Because of considerable hospital expansion and clinical services, the need for additional nursing staff was seen as an urgency. The concept of the introduction of this new worker was not readily accepted by the Matrons and Sister Tutors on the committee, and suggestions for increasing the number of student nurses over a four-year period were presented. Because of the unsatisfactory ward conditions under which students received their training it was felt that another level of staff would compound the situation. Despite these objections, the proponents argued it would be better to have trained nursing assistants than untrained ward assistants which obtained at that time. The Chairman emphasized the need for long-term planning, and it was impressed upon the members the necessity for putting to government the justifiable needs of the Department on a five-year basis "without anticipating government's intentions with regard to availability of funds or personnel." There was ultimately unanimous agreement by the committee that the question of training nursing assistants was worthy of investigation. They further advocated that it was necessary to ensure the adequacy of the salaries of nursing staff so that they were comparable with those paid similar staff in the United Kingdom; that conditions of service in Trinidad should be improved to enhance the prospects of recruitment; and that it was necessary for government to increase qualified staff and provide funds for that purpose (Minutes of March 22, 1957).

A further meeting of the Education Committee on 3 June 1957 centered again on the education of student nurses. Members called for the provision of a Central Preliminary School, and discussed the possibility of bridging the gap between Primary School Leaving (14 to 15 years) and entrance to the Preliminary Training School, by providing post-primary education which would include suitable subjects for girls who were interested in a nursing career.

The Three Five-Year Development Plans of the government as well as the First National Health Plan (1967-1976) contained many of these recommendations as well as those from the Julien Report (1957). Action on some fronts was almost immediate especially with regard to the preparation of staff for leadership positions.

Preparation for Leadership

The aspirations of nurses in earlier years with regard to preparation for assuming leadership roles did not go unheeded. It was in tune with the government's philosophy of developing ~~its nation~~als for leadership in all areas of the nation. Consequently, a great thrust was put into the preparation of Nursing Educators and Administrators as a precursor to assuming the leadership responsibilities of Nurse Education and Administration by nationals of Trinidad and Tobago. In 1957, six scholarships were awarded to nurses for post-graduate study in the United Kingdom, two for the Health Visitor Tutor's Course, one for Nursing Management for Community Health, and three for the Sister Tutor's Course. It was the first time that a substantial number of local nurses were given the opportunity to demonstrate that they possessed the intellectual capacity for further education and could thus attain vertical mobility (Foster, n.d.).

B. The Development Plans: Focus on Health

The Three Five-Year Development Plans
1958-1962; 1964-1968; 1969-1973

It was recognized from the outset that the economic well-being of the society was linked closely to health factors. Health, therefore, occupied a central place in the First Five-Year Development Plan. Moreover, attention had already been directed to the health services through the Report of the Julien Commission. Many of the recommendations from the Nursing Education Committee and the Julien Commission were incorporated into the Plan. Among the Plan's priorities was the provision of funds for extensive health facilities expansion which included the construction, in 1960, of a Central Preliminary Training School, in San Fernando, for nursing students. A new maternity block at the General Hospital, Port-of-Spain was designed to accommodate 150 expectant mothers, a new five-storey block was erected to accommodate 526 beds with an operating theatre, and remodelling occurred at both the San Fernando and the Mental Hospital to provide for additional bed occupancy. Other projects included the development of health care centers and renovations to nurses' quarters.

Within the framework of the Second and Third Development Plans, health continued to occupy a pivotal position. Health was recognized as having an important role to play in the nation's socio-economic development, and the provision of health requirements was seen to be in large measure the responsibility of the public sector of the economy. The achievement of political independence in 1962 had produced drastic changes in the total socio-economic pattern of the country. This, in turn, altered the nature, volume, and quality of the demands which were made on the health services. These concerns were reflected in the Second Five-Year Development Plan which stated:

> ... The long-run objective of our national development must now be the full utilization of our human and natural resources together with our capital resources so as to yield to the broadest segments of our society such levels of living as are commensurate with modern requirements of human dignity (cited in Chen and Comissiong, 1967:178).

Of great significance was full membership in Pan-American Health Organization (PAHO) in 1964 from which came practical assistance in the ensuing years. Specialists in the field of health service planning and administration were provided by PAHO/WHO which led to a variety of training programs developed by the government to develop skills and knowledge in public administration at different levels of management (Chan, 1975:27).

The First National Health Plan 1967-1976

A crucial component of the Second Five-Year Development Plan was the proposal for the development of a National Health Plan. This First National Health Plan 1967-1976 was of historic importance. It was prepared by the Ministry of Health with the active cooperation and advice of the PAHO/WHO Advisor on Planning in both the preparation of the Plan and in its initial stages of implementation.

A Sectoral Planning Committee, established in 1965, was to be responsible for the assessment of the level of health in relation to the socio-economic development of the country, formulation of the National Health Plan, development of an organization for implementation of the Plan, and periodic evaluation of the Plan during its implementation phase, modifying it where necessary (Chen and Comissiong, 1967:179).

The state of the health services, at the time of independence, had been largely fashioned and moulded by the country's socio-political history dating from the early colonial times. While considerable improvements had been achieved, yet the evolution of the health services had been fragmentary, unbalanced, unsystematic, and confined mostly to the implementation of isolated or sectoral projects which accounted for the disparity in the standards of service provided, and for the many technical and administrative problems encountered (NHP, 1967:7).

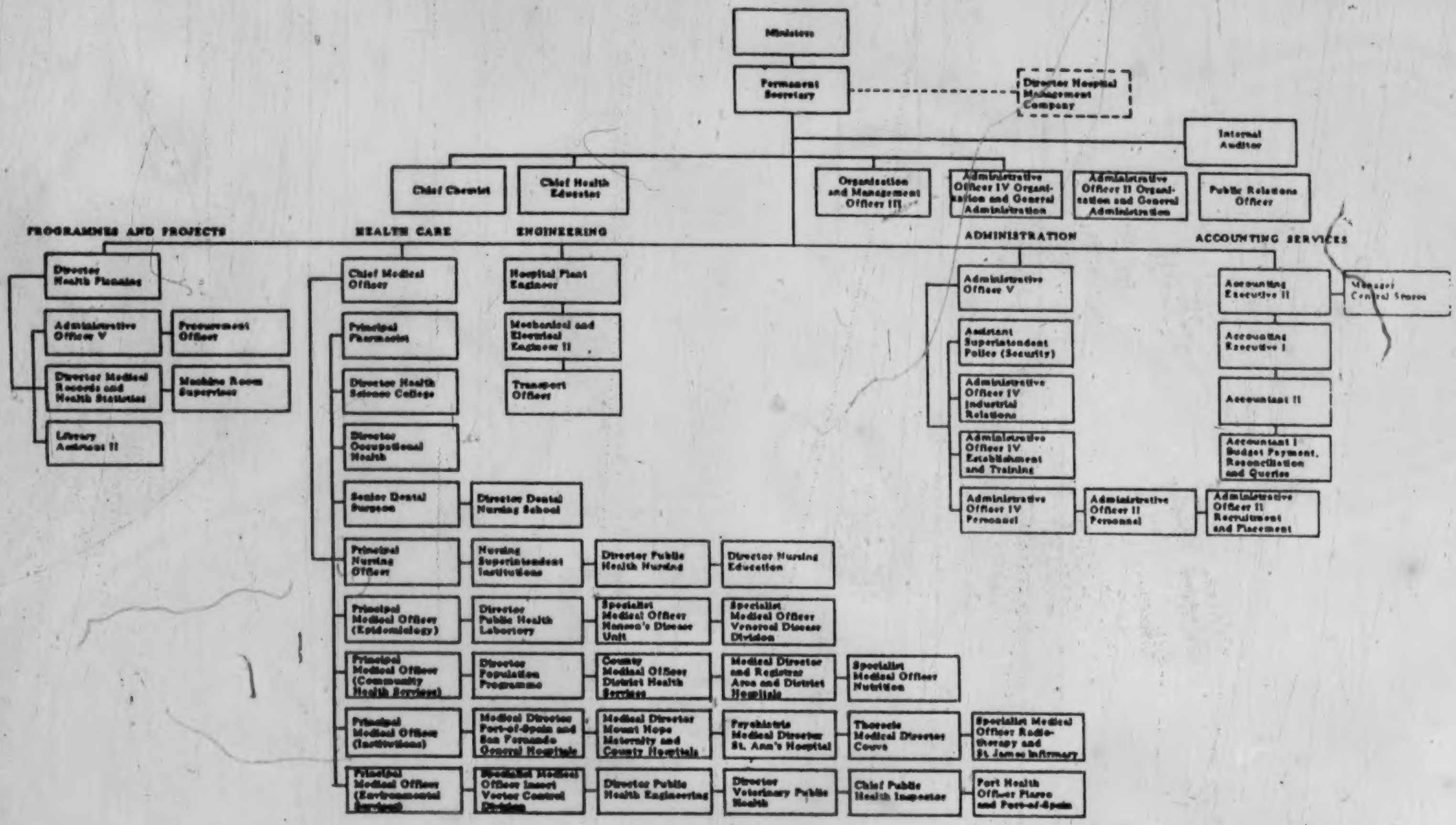
An important reorganization occurred in 1962 in the health services as a result of the Lee Report (1959). The old administrative system where the Director of Medical Services was the Head of Health

Services was replaced by the new Permanent Secretariat system. The work of the Health Services was now divided into two sections--technical (or professional) and lay services. This initially created friction between lay and technical parts. The Director of Medical Services now received official communication from the Permanent Secretary who reported directly to the Minister of Health. Moreover, medical and health recommendations and opinions were now critically examined by the lay administration and subject to change without the knowledge of the medical personnel. After a period of settling-down, these difficulties were overcome and the dual system persisted with greater cooperation and goodwill (Chan, 1975:24). Figure 4 shows the new ministerial organizational structure with administrative and professional services.

During the 1960s the population was growing at an alarming rate with an annual average rate of growth prevailing at 2.8 percent. Primarily responsible for the rapid growth was an increase in birth rate coupled with a decline in death rate, particularly the infant mortality rate. Between the years 1957-1967, infant mortality ranged from a high of 62.7 per 1,000 to a low of 35.5 per 1,000; death rate declined from 9.5 to 6.7 per 1,000 and birth rate fluctuated between a high of 39.1 to 28.2 per 1,000 (DP III, 1968:98). With hospital expansion, including the new maternity wing, nearing completion in 1962, the government was approached by the University of the West Indies to utilize the clinical facilities for expansion of the medical school. The government readily agreed to the conditions which required construction of a Medical Records Department, a Medical Library, and a Dormitory for medical students. Thus, in 1967, the Port-of-Spain

Figure 4

New Ministerial Organizational Structure Introduced in 1962 (Administrative and Professional Services)


Ministers
Permanent Secretary
Director Hospital Management Company
Internal Auditor
Chief Chemist
Chief Health Educator
Organization and Management Officer III
Administrative Officer IV Organization and General Administration
Administrative Officer II Organization and General Administration
Public Relations Officer
PROGRAMMES AND PROJECTS
HEALTH CARE
ENGINEERING
ADMINISTRATION
ACCOUNTING SERVICES
Director Health Planning
Administrative Officer V
Procurement Officer
Director Medical Records and Health Statistics
Machine Room Supervisor
Library Assistant II
Chief Medical Officer
Principal Pharmacist
Director Health Science College
Director Occupational Health
Senior Dental Surgeon
Director Dental Nursing School
Principal Nursing Officer
Nursing Superintendent Institutions
Director Public Health Nursing
Director Nursing Education
Principal Medical Officer (Epidemiology)
Director Public Health Laboratory
Specialist Medical Officer Hansen's Disease Unit
Specialist Medical Officer Venereal Disease Division
Principal Medical Officer (Community Health Services)
Director Population Programme
County Medical Officer District Health Services
Medical Director and Registrar Area and District Hospitals
Specialist Medical Officer Nutrition
Principal Medical Officer (Institutions)
Medical Director Port-of-Spain and San Fernando General Hospitals
Medical Director Mount Hope Maternity and County Hospitals
Psychiatric Medical Director St. Ann's Hospital
Thoracic Medical Director Couva
Specialist Medical Officer Radio-therapy and St James Infirmary
Principal Medical Officer (Environmental Services)
Specialist Medical Officer Insect Vector Control Division
Director Public Health Engineering
Director Veterinary Public Health
Chief Public Health Inspector
Port Health Officer Piarco and Port-of-Spain
Hospital Plant Engineer
Mechanical and Electrical Engineer II
Transport Officer
Administrative Officer V
Assistant Superintendent Police (Security)
Administrative Officer IV Industrial Relations
Administrative Officer IV Establishment and Training
Administrative Officer IV Personnel
Administrative Officer II Personnel
Administrative Officer II Recruitment and Placement
Accounting Executive II
Manager Central Stores
Accounting Executive I
Accountant II
Accountant I Budget Payment, Reconciliation and Queries

SOURCE: Annual Report of the Ministry of Health, December 31, 1980.

General Hospital became a Teaching Hospital of the University. By then, bed capacity had increased by 50 percent since 1960 to 900 beds (Chan, 1975:25).

The picture of the level of health by the late 1960s indicated that problems such as diabetes, nutritional deficiencies, and mental illness were increasing. There was a greater demand for health services due not only to population growth but also because citizens through education, economic considerations, and acquired habits were demanding more from the health services (NHP, 1967:42). It is in such a health climate that the First National Health Plan was formulated. The Health Plan was optimistic. It hoped to find "a formula which [would] supersede the vain search for efficiency through the recommendations of repeated commissions of enquiry of which there [had] been five during the past two decades" (p. 7). It sought "to achieve the maximum level of health in the shortest possible time limited only by factors contingent on our overall rate of socio-economic growth and by the availability of technical knowledge and skills" (p. 48). The Plan consisted of four parts:

1. An assessment of the health situation of the nation, including the technical and administrative problems in the health service, and an analysis of the financial implications which was 10.82 percent of expenditures in the public sector in 1966;
2. Criteria for establishing priorities including a detailed analysis of the cost-benefit ratio;
3. A statement of the Official Health Policy followed by a definition of specific objectives and decisions on performance targets for the subsequent ten years; and

4. Implementation plans which outlined the new ministerial organizational structure, and defined the three major programs--Integrated Medical Care, Environmental Health, and Epidemiology.

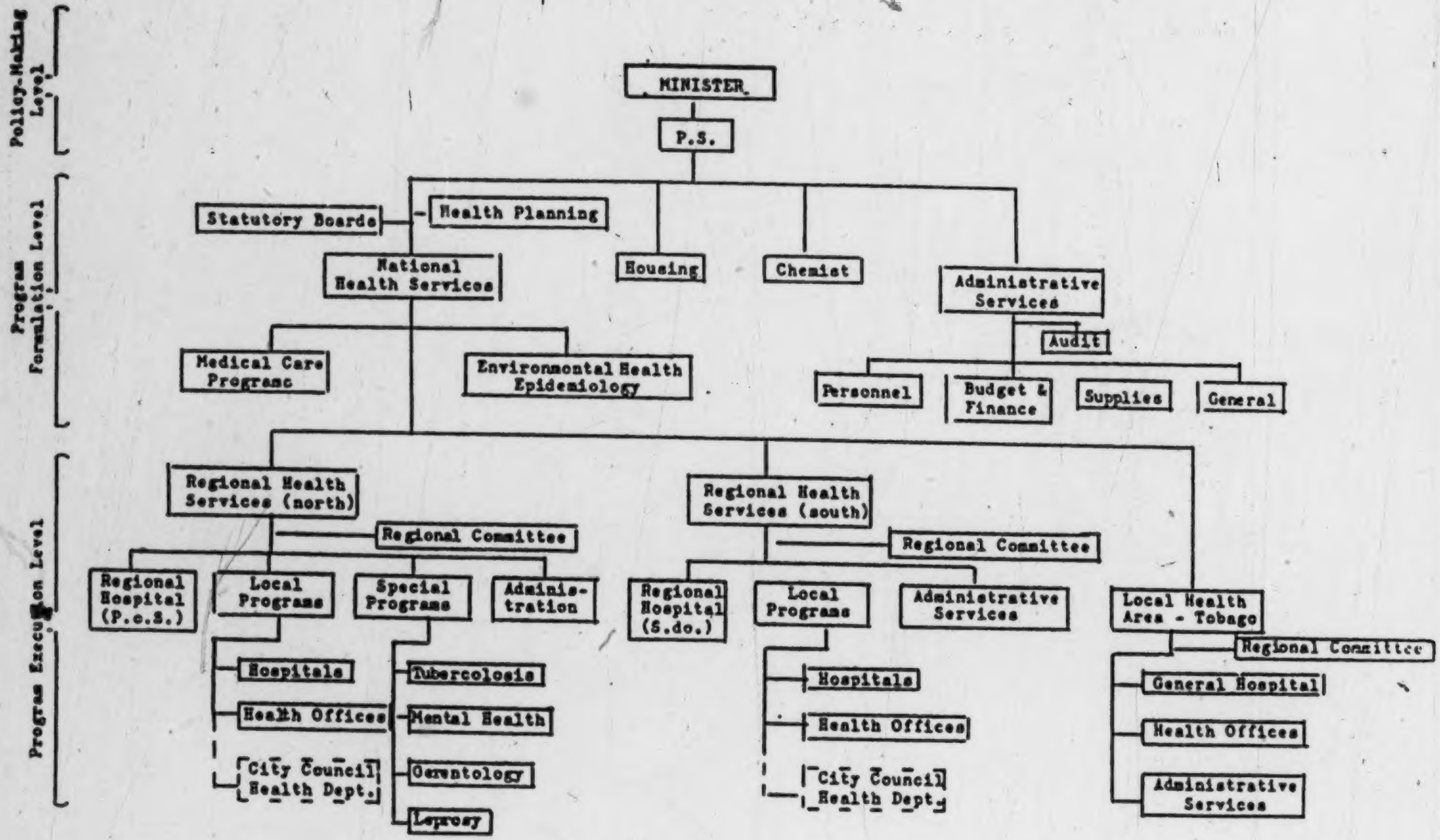
A priority in the Plan was the reorganization of its health services to integrate its curative and preventive services. This included the reconstruction and relocation of its district health services. The objective was to strengthen the health care system at district levels thus decentralizing the health services at the regional levels. By 1970, the government had signed its first loan agreement with the World Bank and six (6) Health Care Centers were constructed (Interview, February 26, 1986; Loan Agreement, 1971). The Ministry of Health in its continuing effort to improve and increase the coverage of the health services of the country erected a further 26 suburban and rural health centers throughout the country with a loan, in 1974, from the Inter-American Development Bank (IADB). On completion, the project provided health services to approximately 200,000 low-income suburban and rural clients who until then lacked medical care (PAHO, n.d.).

The Plan also specified future needs with respect to manpower requirements and training of professional staff. Nursing was addressed in great detail. It posited that a total of 1,370 graduate nurses would be required in the first year of implementation of the Plan, and 1,719 for the tenth year--an increase of 347 over the ten-year period. Training facilities for 822 student nurses were to be maintained in 1967 and to be gradually reduced to 600 throughout the remaining period of the Plan. With regard to nursing assistants, it projected that 445 nursing assistants would be needed in the first year of the Plan, 705 in the fifth year, and 829 in the tenth year--an increase of 384 over the ten-year period. Further, approved training courses for all nursing assistants were to continue throughout the period of the Plan (NHP, 1967:72).

Another important feature proposed in the Plan was reorganization of the organizational structure at central command (that is, the senior professional administrative group located at the Ministry of Health). The new internal structure aimed at decentralizing authority for program execution. It provided for three levels of responsibility and authority--policy decision, policy and program formulation, and program execution. The **policy decision** level comprised the Office of the Minister of Health and of the Permanent Secretary. It provided general direction, supervision, and control of the Ministry, interpretation of governmental policy, and approval of programs. The **policy and program formulation** level comprised the Office of the Chief Medical Officer (CMO) which was responsible to the Minister, through the Permanent Secretary, for the direction and management of the national health services. Under its immediate supervision was the central organization of the Ministry responsible for programming. Other components of the organization under the Office of the CMO were a Health Education Unit and the Division of Nursing, both of which performed a combination of executive and advisory services common to all programs. The **program execution** level was the regional organization (North, South Trinidad and Tobago) in charge of carrying out approved programs and projects (NHP, 1967:61-63). Figure 5 illustrates the revised organizational structure effected in 1967 to provide for decentralization.

Figure 5

Revised Organizational Structure in the Ministry of Health - 1967


Policy-Making Level
Program Formulation Level
Program Execution Level
MINISTER
P.S.
Statutory Boards
Health Planning
National Health Services
Housing
Chemist
Administrative Services
Audit
Medical Care Programs
Environmental Health Epidemiology
Personnel
Budget & Finance
Supplies
General
Regional Health Services (north)
Regional Committee
Regional Hospital (P.o.S.)
Local Programs
Special Programs
Administration
Hospitals
Health Offices
City Council Health Dept.
Tuberculosis
Mental Health
Gerontology
Leprosy
Regional Health Services (south)
Regional Committee
Regional Hospital (S.do.)
Local Programs
Administrative Services
Hospitals
Health Offices
City Council Health Dept.
Local Health Area - Tobago
Regional Committee
General Hospital
Health Offices
Administrative Services

SOURCE: Chen, G., and Comissiong, Dr. L. Organization for Health Planning in Trinidad and Tobago, A Working Document. Ministry of Health and Housing, November 1967.

The authors of the Plan were aware that there were factors militating against the efficient functioning of the health services. They commented: "the greatest single obstacle to be successful implementation of this or any health plan is the shortage of trained personnel, it is imperative that terms and conditions should be made as attractive as possible in order to acquire and retain the services of suitable officers in the Public Service" (p. 71). As a result, a training program for all levels of staff was given high priority. The training of top administrators, supervisors, and teaching staff was to be financed partly by fellowship grants through international and bilateral agreements. The IADB provided funds for contracting consultants to advise the government on improving its administrative and financial systems, as well as on upgrading the technical and professional personnel who were to be responsible for administering and operating the health center projects (PAHO, n.d.).

Because of this extensive National Health Plan, in the Third Five-Year Development Plan (1969-1973) the focus on health was to note the improvements and the problems in the Health Services since the previous Development Plan. In relation to shortage of staff it recommended that "to reduce the cost of providing an adequate supply of nurses it [was] necessary to step up the in-service training programs for nursing assistants" (p. 302). Its highest health priority was to curtail population growth through a National Family Planning Program. A Population Council was appointed to work with religious and community groups and the aim was to halve the birth rate in a decade (DP III, 1970:73; 307).

The Health Plan provided a framework which was used to develop programs in the health field of which nursing played a significant part.

The Decade Beyond the Health Plan, 1976-1986

Subsequent to the first Health Plan, with the economic boom in the mid-1970s, contingency or ad hoc planning prevailed. Long-term planning lost its mystique, and planning became more centralized with the Ministry of Finance and Planning doing the planning for all sectors. Sectoral planning was de-emphasized. Between 1976-1982, there was intensive physical facilities building without individual physical facilities programming (Interview, February 28, 1986). A new maternity hospital (110 beds) was built in the eastern part of the island at Mount Hope to relieve the pressures on the maternity services at the Port-of-Spain Hospital, and because of the difficulty experienced by medical and dental students in obtaining places at medical institutions abroad, the government decided to establish a Medical, Dental, and Nursing School in Trinidad in collaboration with UWI. The Mount Hope Medical Complex was planned to be the teaching hospital with 390 adult beds and 210 paediatric beds, in addition to the maternity complement (Ministry of Health, 1978).

It was during this time, 1976, that the Minister of Health attended the Third Special Meeting of Health Ministers of the Americas in Washington. At that time all member countries of PAHO reaffirmed the decision to bring about as quickly as possible the extension of health coverage to all unserved areas using the strategy of primary health care and community participation (Annual Report, 1977). In 1978, the government was signatory to the Declaration of Alma Ata, and accepted the strategy of Primary Health Care to achieve the goal set by WHO "Health for All by the Year 2000." This, in fact, was a reaffirmation of the basic framework of Primary Health Services which had existed in the nation since 1970. Notwithstanding this, the intent was to evaluate, modify, and strengthen the existing services and introduce new concepts in an effort to realize the goal (Annual Report, 1980).

By 1983, the planning process was underway, for the development of a Second Health Plan, through the Policy Planning Committee of the Ministry of Health. It comprised the Chief Technical (Professional) Officers and the Heads of the various supportive areas which included nursing as a key area. The purpose of the committee was to plan programs and facilities for effective delivery of the health care services (Interview, February 28, 1986).

Meanwhile, construction of the Mount Hope Medical Complex commenced in 1981 and was completed in 1985 at a cost of $657.4 million dollars (TV Broadcast, March 1986). The goal of the government was to have the most modern diagnostic facilities to assist medical personnel in patient care investigation. But increasingly, the question was raised as to whether government was able to maintain this superstructure in terms of its recurring costs. While facilities were available for a medical, dental, and nursing school, the Complex, in 1986, was not yet operational in either its services or teaching programs. With the country in an economic recession, the lack of human and physical ~~re~~sources was apparent. The edifice nestled on 140 acres of sprawling lands in the east of the island stands deserted (except for its maternity wing) as a testimony to the value that had been placed on the expensive high technology field of health care in a developing nation. Criticism has been levied at the government for proceeding with th~~is~~ sophisticated institution at the expense of further public health initiatives. A Health Surcharge, paid by citizens, implemented in 1985 failed to raise the revenue expected which implied that there would need to be other sources of revenue in order to finance the Medical Complex (TV Broadcast, April 1986). Health Services had always been without charge; with the completion of the Medical Complex, additional resources were required to support those services. Consequently, the government was exploring the possibility of introducing a national health insurance scheme. In the interim, a surcharge on national insurance contributions was introduced to assist in defraying the cost of the health services (Budget Speech, Prime Minister, 1984:91).

In summary, over the past 30 years, since self-government, the Health Services had attempted to integrate its curative and preventive services through decentralization. There was a fairly well-developed public health system that had enabled the country to achieve an acceptable standard of health. The health situation, in general, approached the state of affairs found in the advanced countries. The main causes of death were those connected with the heart and cerebro-vascular system, cancer, and accidents. As well, there were sharp declines in the traditional main causes of death such as tuberculosis, typhoid, and other infectious diseases. The morbidity had declined from 41.5 per 1,000 to 23.7 per 1,000 (DP III, 1968:98, 307).

Statistics for 1980 indicated a death rate of 6.7 per 1,000 and infant mortality had further declined from 28 in 1978 to 19.7 per 1,000, with life expectancy in 1978 at 70 years. In 1986, 7 percent of the total global budget was allocated to health, exclusive of expenditures allocated to other agencies and ministries also designed to enhance public health standards. In addition, there was a network of 102 health centers throughout both islands. These provided a vital service in general medical, ante-natal, and child health clinics. Other programs such as immunization, family planning, dental care, clinics for sexually transmitted diseases, and Hansen's disease were provided. The country had also moved into the high technology field of tertiary care with the establishment of intensive care units, and in the secondary care system, along with expansion of existing facilities, a new Medical Complex was constructed (Minister's speech, 1984). Since nursing is the major provider of human resources for the delivery of health care in the country, these early and later developments had significant implications for nursing and nursing education.

C. Regional Nursing Cooperation

The newly formed Federation of the West Indies in the period between 1958-1961 greatly facilitated regional cooperation of both a governmental and non-governmental nature in nursing. Despite the dissolution of the Federation, the framework was laid for collaborative efforts which have continued to the present time. In Trinidad, these external influences had a significant role to play in the progress of nursing education. This section describes these regional activities from their initial stages to the 1980s.

Caribbean Nurses Organization (Non-Governmental)

The nurses of the Caribbean had felt the need for regional cooperation for a long time and successive reports on the Colonial era had advocated same (MacManus, 1947; Moyne, 1940; Russell, 1944). While there had been inter-island communication from time to time, it was not until 1957, in Antigua, that a group of nurses headed by Mavis Harney Brown, called a conference to inaugurate a Caribbean Nurses Organization (TTRNA, n.d.:20). The main objective was to assist the territories to achieve some common acceptable standards of education for nurses. The organization encompassed not only the British Territories but included the French and Dutch West Indies, Puerto Rico, and the American Virgin Islands. It met biennially in different member countries. Membership was of two types: (a) group membership through a territorial professional association or (b) individual membership. There was no obligation on the association of a particular territory to join but the associations have done so. The Organization has maintained valuable links with the International Council of Nurses through regional area representation and individual territorial membership. It further has remained a valuable means of non-governmental coordination, cooperation, encouragement, and stimulation for the benefit of Caribbean nursing education and health care.

First Nursing Administrators Conference (Governmental)

On August 31, 1959, a group of senior nursing personnel from the Commonwealth Caribbean came together to discuss the problems confronting them. The met in an era marked by rapid political, educational, and socio-economic change in which a much closer relationship had developed between the territories. Under the auspices of the newly-formed Federal Government of the West Indies, Dr. Horace Gillette, Federal Medical Advisor, chaired that historic Conference of Caribbean Nursing Administrators in Barbados. Its terms of reference were:

(1) to study, compare, and evaluate the nursing needs of the Unit Territories of the Federation, British Guiana, and British Honduras.
(2) to discuss the educational requirements and training of nurses; and
(3) to discuss the possibility of the establishment of a Federal Nursing Register with reciprocity within the federation and other countries overseas (Report of NA, 1959:1).

Hopes were high by all, medical as well as nursing personnel, to find solutions to the many problems facing nursing in the territories. Nita Barrow*, distinguished and renowned Barbadian nurse, who was then Principal Nursing Officer for Jamaica, in her speech at the opening ceremonies, expressed such sentiments eloquently:

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*Now Dame Nita Barrow.

> ... We are therefore grateful for this Conference and welcome it as an opportunity to look at our needs realistically and we hope in a fashion which leaves us unafraid. We have to consider the light of modern trends because changes which are taking place in our own profession like that of many others cannot be kept back any more than the tides of the sea ... We hope at the end of this period which we share we shall have a much clearer vision not of the problems because they bow us down but of some of the solutions towards which we can work and go forward in that spirit into what appears to be a challenging and exciting future ..." (Report of NA, 1959:Appendix V).

It was in such a mood of enthusiasm that the whole spectrum of issues confronting nurses in the region was explored through sub-committees, with subsequent recommendations. Manpower needs, socio-economic matters, post-graduate training, the establishment of professional organizations, reciprocity of registration, and the training of student nurses highlighted only a few of the topics which were discussed.

The sub-committee which addressed the education of student nurses was in agreement that it was desirable to have a minimum educational standard for all territories, and suggested the designing of an educational test that would be an accommodation of varying standards. It advocated encouraging prospective candidates to continue beyond the school leaving certificate by the provision of courses in English, Arithmetic, and the Health Sciences, at a more advanced level in order to better prepare them for further training (Report of NA, 1959:Res. 182). Evolving from this Conference was a Steering Committee whose task was to oversee the implementation of the recommendations of the Conference, and later on to function in the role of an Advisory Committee to a proposed Federal Nursing Officer.

The Steering Committee met in Trinidad in 1961 to carry out its task as envisioned by the Conference group. It recommended a survey of schools of nursing in the territories in order to ascertain the educational standards and needs of the area. Verna Huffman*, a Canadian, who was the WHO Nursing Consultant to the Federal Government and stationed in Trinidad at that time, gave much assistance to the group in their quest for international aid for the evaluation of the educational programs in the area. Despite the demise of the Political Federation in 1962 the WHO Nursing Consultants, Verna Huffman and Janet Thompson, kept the spark alive (Interview, January 31, 1986).

By 1963, the plan which was formulated by the Steering Committee was submitted to PAHO/WHO. This led to the development of a project beginning with a survey of the 23 schools of nursing which included British Guiana, British Honduras, and the Bahamas who were invited to participate as their education programs also followed the British pattern. In 1965, Dr. Helen Mussallem, Executive Director of the Canadian Nurses' Association, was loaned as a short-term consultant to the project and Nita Barrow, Principal Nursing Officer of Jamaica was seconded to WHO to head the project. Barrow brought with her a thorough knowledge of the problem as well as a rich background and education, and Dr. Mussallem, with her considerable experience and expertise rendered extremely valuable assistance to the project throughout the stages of development, its execution, and subsequently.

Many members of the Steering Committee which recommended the survey served on the Advisory Committee to the project, and later became a Board of Review for the evaluation of the Schools of Nursing in the 13 territories (PAHO/WHO, 1966:16).

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*Now Huffman-Splane.

The criteria used in evaluating the schools were those utilized by Mussallem in the Canadian survey of nursing education programs after adaptation and modification for use in the area.

In association with this project four seminars were held in various territories. The first two were directly concerned with the execution of the survey, a review of the survey findings, final assessment of the schools, and planning for the future. Participants were primarily senior administrative nursing personnel. One of the recommendations of the second seminar held in Antigua in 1965, advised that members of the teaching staff of the nursing schools hold a seminar "to work out a curriculum suitable for the preparation of nurses of all categories" (PAHO/WHO, 1966:75). Consequently, the third seminar on nursing education in January 1966 brought together those responsible for nursing education programs in the area and guidelines were developed to be used in planning basic nursing programs appropriate to the Caribbean. The fourth seminar was held in Guyana in 1968 to evaluate the progress in improvement of nursing education in the countries involved and to assist the teaching staff in curriculum development. PAHO/WHO advisors provided assistance throughout the conduct of these seminars in addition to Dr. Helen Mussallem.

That seminal Conference of Caribbean Nursing Administrators in 1959 wrote a charter for the future direction of nursing and nursing education in the Commonwealth Caribbean. It led to the first North American influence on nursing education and considerably reduced the single influence of British nursing in Trinidad and Tobago (Interview, January 31, 1986). Moreover, it laid the foundation for the establishment of a Regional Nursing Body. This was a recommendation of the group participating in the Nursing Education Seminar in Antigua in 1965 held at the completion of the Survey of Schools of Nursing.

Regional Nursing Body

The Regional Body was envisioned as being responsible for accreditation of schools, offering advice and assistance in improving standards of nursing education, and conducting periodic evaluation of programs (PAHO/WHO, 1966:76-77). The recommendation was endorsed at the Nursing Education Seminars held in Jamaica in 1966 and Guyana in 1968, and further discussed in Dominica at a seminar organized by PAHO/WHO in 1969. In that year, at the First Conference of Caribbean Health Ministers, a resolution was passed endorsing the establishment of such a Regional Nursing Body (CHMC, 1970).

Because of the continued interest a meeting was sponsored by the Commonwealth Foundation in Barbados in April 1970. Funding was provided by the Foundation for a group of 12 senior nurses from the Commonwealth Caribbean to meet with two Canadian and two British nurses as consultants and two resource persons from the Caribbean. Three PAHO/WHO nursing advisors were also invited. The purpose was to consider the recommendation of establishing a regional nursing body. This was unanimously accepted by the group and a Steering Committee was appointed to continue working on its development. Further a re-survey of schools to be conducted by PAHO/WHO was requested of

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territorial governments (PAHO/WHO, 1971:4). Their report was presented at the second Conference of Caribbean Health Ministers in April 1970. The Conference agreed in principle to the establishment of a Regional Nursing Body and approved the request for the re-survey of nursing schools (CHMC, 1970). Formal approval for the Regional Nursing Body was eventually expressed at a later Health Ministers Conference in 1972, and a new dimension in the development of nursing education in the Caribbean was achieved.

In the meantime, in 1968, Dr. Mussallem who undertook the original survey was assigned the responsibility for directing the re-survey. The purpose was to assess progress in the improvement of nursing school programs, to provide guidance in areas needing improvements, and to gather data on the current status of nursing schools which could be utilized by the Regional Nursing Body when formed (PAHO/WHO, 1971:15).

The Board of Review after careful study of each of the 23 programs concluded that six schools met the criteria agreed upon, seven others needed slight improvements to be acceptable, and nine continued to need considerable help although they had made marked improvements. Each school received documents indicating the strengths of the present program and those areas requiring improvement (PAHO/WHO, 1971:60). In Trinidad, only one school met the criteria (Interview, January 10, 1986). Following the re-survey, the concerns for professional standards in the region continued on a cooperative basis through mechanisms such as seminars, the Caribbean Nurses Organization, and the Regional Nursing Body.

The Body, however, did not materialize as it was envisaged. It was envisioned as an independent unit with the professional organizations playing a leading role assisted by the government. It had become, instead, a quasi-governmental institution now operating within the Caribbean Health Ministers' Conference and under the aegis of the CARICOM Secretariat in Guyana (Interview, January 31, 1986). The representatives were the chief nursing officers or senior administrative personnel of the territories.

In 1976, the Regional Body placed the development of Regional Examinations for professional nurse registration as a major priority. A feasibility study carried out in 1976 established the fact that 13 Commonwealth governments agreed, in principle, to the concept of Regional Examinations for nurse registration. A workshop at Dover, Barbados, provided a document which included common aspects of nursing considered essential for nurses seeking registration in the region. The Dover Document formed the background material for the development of a Blueprint. Under the sponsorship of the Canadian Nurses' Association (CNA), the Canadian International Development Agency (CIDA) approved the funding of the Regional Nurse Registration Examinations Project. The nurses of the region attended a series of workshops between November 1980 and 1982 which culminated in the development of the Blueprint. The Blueprint outlined the rationale for Regional Examinations, and it included the philosophy, goals, objectives, and content outlines of nursing and the relevant supporting sciences. This provided a ready reference on Regional Nurse Registration Examination (CARICOM, 1976:1-2).

The project was planned for three years with the intent of having the first Regional Examination by the end of the third year. With the project completed, Councils of the various territories were requested to examine, in consultation with their legal departments, the relevant existing laws to ascertain whether amendments might be necessary in order to introduce the proposed regional examinations (CARICOM, 1983).

In Trinidad, because of the nature of the Regional Body as a quasi-governmental agency, the national government chose representatives to participate in the development of Item-Writing for the Regional Examinations instead of the Nursing Council which had the legal responsibility for examinations. This created tensions and was "a major factor in the considerable lack of interest on the part of the Council in the Regional Nursing Body and its activities" (Nursing Council Report, 1983:15). To date, 1986, the examinations have not yet been implemented in any of the territories.

Regional Preparation for Leadership

The Advanced Nursing Education Unit at the Mona Campus, Jamaica, University of the West Indies (UWI) was yet another cooperative venture which involved UWI, the government of Jamaica, and PAHO/WHO. It was established in 1966 to provide a one-year post-basic program leading to either a Certificate in Nursing Education or Nursing Administration. The program grew out of a long-felt need to upgrade the preparation of nurses for leadership positions in the health services of the region, and to do so within the cultural and socio-economic framework of the Caribbean (Sievwright, 1974:7). The concept for such a program was mutually discussed at the Second Nursing Education Seminar in Antigua in 1965. UWI representatives from the Institutes of Education and the Jamaican government who were invited to the seminar outlined plans for the development of an advanced nursing education program to prepare nurse tutors and administrators (PAHO/WHO, 1966:77). The Certificate program was seen as an initial step in a long-range plan for the development of nursing leadership for the improvement of health care in the Caribbean.

The need for a Bachelor of Science degree with a major in nursing was a recommendation at both the Nursing Education Seminar in Guyana in 1968, and at the First Caribbean Health Ministers' Conference in Trinidad and Tobago in 1969. This program was intended to be the logical second step in the long-range plan. A plan for evaluating the Certificate program and investigating the basis for a degree program in nursing was formulated with the assistance of a PAHO short-term consultant. Further, a proposal was developed which called for a three-year post-basic program setting forth its aim and objectives and the target population. Almost 13 years after submission of the proposal, the degree program commenced in 1983.

These various forms of regional cooperation--governmental and non-governmental--greatly influenced nursing education in Trinidad through its Nursing Division and the Nursing Council.

D. The Nursing Council

The Nursing Council, from 1954 to 1957, directed its attention towards the improvement of standards and facilities for training in the schools of nursing. It relied considerably on the knowledge, expertise, and written documentation of the General Nursing Council of Great Britain and Wales with respect to the education of student nurses in order to improve on the deficiencies identified in the Houghton Report (1953). As a result, in 1957, an amendment to the Nurses Ordinance conferred on the Council responsibility for Male Nurses, Mental Nurses, Sick Children's Nurses, and Nurses for Tuberculosis Patients.

The Entry of Males in Basic Nursing Education

The route by which males first entered nursing was through the mental health field. Nursing, similar to other parts of the world was, and still is, seen primarily as a female profession, and the role of males in nursing was limited to male attendants. This was particularly so at the St. Ann's Mental Hospital* where the training of institutional staff was provided on an apprenticeship system for probationary attendants. They (male and female) learnt on the job for three years or more and were eventually appointed on staff dependent on vacancies and whether additional staff could be hired.

With the enactment of the Mental Treatment Ordinance in 1940, probationary attendants were then called Student Nurses although the apprenticeship system continued for more than ten years after the

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*It is now called St. Ann's Hospital.

Ordinance. It meant, however, that those who cared for the mentally ill were not limited to being attendants but could receive training and move on to higher levels. They could become nurses not mere custodians (Nicholas, 1975:29). The new local recruits and the nursing staff were now designated student nurses, and during their first year they received a three-month course of lectures on Anatomy and Physiology, First Aid, and the Duties of a Mental Nurse. At the end of 12 to 18 months they sat an examination set by the Medical Superintendent. The successful candidates were then appointed as nurses. This system persisted up to 1952 but from 1943 some bedside teaching was done. With the advent of Insulin Coma Treatment in 1949 the government decided that the program was to be extended to four years (Beaubrun, n.d.). Considerable improvements in nurse training were introduced in 1955 and a Certificate of Proficiency in Mental Nursing and a Hospital Badge were issued to all students who passed the final examination from 1956 onwards (Lewis, 1975:31).

Meanwhile, government scholarships were provided to local nurses to train in England in order to prepare them to assume leadership positions in nursing service and nursing education in the mental hospital (Nicholas, 1975:29). The first Sister Tutor for St. Ann's Hospital, a local nurse, was appointed in 1954 and a Nursing Training School was built on the site in 1963 (Lewis, 1975:31).

Gender difference continued to be perpetuated in the hospital through its administrative arrangements where the institution wasr divided into male and female sections, with a corresponding male and female staff, including a Senior Matron (female) and a Chief Male

Nurse. With the Nursing Council assuming responsibility for the curriculum, examination, and registration of mental nurses and male nurses in 1957, there were improvements in the mental nurse training. More importantly, males could now be trained as general nurses, and procedures governing their training were drafted. These stated:

> Males should not nurse in female wards. Lectures may be taken with female colleagues. With respect to examinations where a question in gynaecology is concerned, one in genito-urinary diseases would be set for males. Males must wear a distinctive uniform ... (Nursing Council, cited in Beckles, 1985).

By 1968, the Port-of-Spain Hospital permitted males to do obstetrical nursing, and San Fernando followed later. While males were accepted in general nursing after 1957, they remained few in number.

Between 1965-1970 there was considerable help under the Canadian Technical Aid Program for mental health nursing with subsequent increases in the teaching staff, and the granting of scholarships to male and female nurses to visit hospitals in Canada. The mental health nursing program was discontinued in 1969 following the Q and Q Survey (1968), and mental health nursing was integrated in the basic nursing comprehensive curriculum in 1968 with a one-year post-basic psychiatric program for registered nurses introduced in 1970. This led to a considerable decline in registered mental nurses which caused the reintroduction of a program for registered mental nurses in 1978.

In 1978, with a modified curriculum, students now shared the first 18 months in common with the basic nursing students and the last

18 months in mental nursing. Over the years, male nurses remained predominantly in the mental health field with a ratio of 1:50 entering general nursing (Interview, January 9, 1986). In 1980, out of a total nursing staff population of 5,847, only 327 were males (Q and Q Survey, 1980:21 and 37).

Registration Reciprocity

Since the Nursing Council's inception the goal was ultimately to gain reciprocity with the General Nursing Council of England and Wales; thus, after the implementation of changes, which included the appointment of a qualified Sister Tutor at each of the Schools of Nursing, as recommended by the Houghton Report (1953), reciprocity was achieved in 1958. This accomplishment provided a "sense of achievement and pride experienced not only by the Council, but by the general public and other West Indian Islands" (Nursing Council, 1975:35).

The Education of the Midwife

The 1960s saw continuing efforts by the Ministry of Health to introduce and regularize several areas of health legislation. The Nurses and Midwives Registration Act 1960 (formally The Nurses Registration Ordinance 1950) ushered in a new era in the young life of the Council when midwives, formerly the responsibility of the Medical Board, became the responsibility of the Council.

the Central Midwives Board of England and was undertaken only by registered nurses. This was still an essential requirement for promotion of staff nurses to positions of ward sister and remained so until the late 1960s ~~when the~~ practice was discontinued (Welsh, n.d.). The other program was a two-year course, introduced in 1957, for non-nurses. The aim of this program was to prepare those untrained persons in the community, "middies" and "traditional birth attendants," to give basic care of acceptable quality to women during pregnancy and childbirth. On successful completion of training these midwives would work in the rural areas and were called panel midwives. Entrance to the two-year program was obtained by passing the Nursing Council's Education Test. This program was eventually phased out in 1974.

An opportunity to continue training in general nursing was available to those midwives with the required academic qualifications and motivation (Interview, February 7, 1986). Midwifery education is now considered post-basic education and registration as a general nurse is required to participate in the one-year program.

The revised Midwives and Registration Act 1960 required further changes in many aspects of existing practice for student nurses such as formulating regulations governing examinations, registration, and recruitment for training (Beckles, 1985:5). These became the focus of attention by the Council.

Entrance Requirements for Nurse Training

Prior to 1951, there were no records kept of student nurses' training and students were selected and admitted directly by the hospitals. With the advent of the Nursing Council, students holding Senior Cambridge School Certificates continued to apply directly to the hospital for recruitment; for the others, an Education Test was devised by the Council, with the first test taking place in November 1951. This system continued until 1964 when all applicants applied directly to the Council. With the introduction of the General Certificate of Education (GCE) in 1963, and the Caribbean Examination Council (CXC), a Caribbean based examination, students holding a GCE or CXC with unsatisfactory subject passes were permitted to take either Arithmetic or English language, as applicable, at the Education Test. By 1975, the Education Test was discontinued. It had served a useful purpose for the time in which few received the benefit of Secondary School Education but it also produced two streams of persons with differing basic qualifications; with one stream, the Education Test recruit who found it difficult to cope with the ever-expanding nursing program (Beckles, 1985:12). Statistics for the years 1965 to 1969 revealed that students admitted with the minimum requirement of a School Leaving Certificate (eight years Primary) ranged from a high of 81 percent in 1967 to 34 percent in 1969 (PNO Report, 1970). In 1977, the requirement was increased to five passes at the GCE "O" level, of these two had to be English language and Mathematics, based on recommendations from reports on student failure in the Registration Examination (Fields, 1975). These remained operational until 1982 when it was reduced to four passes at the GCE "O" level for a period of four to five years. By 1980, students with Primary School Leaving Certificate had declined to 17 percent, with 37 percent having one to four GCE "O" level passes (PAHO/WHO, 1980).

Registration Examinations

In the intervening years since the first examination offered by the Council in 1957, some small changes were made with regard to the Preliminary Examination. By 1959, the oral examination was deleted and the period of practical examination was increased to 30 minutes. There were now two parts to this examination which could be taken together:

Part I - Anatomy, Physiology, and Hygiene

Part II - First Aid and Nursing.

Initially, the Council, in attempting to implement its regulations, came into conflict with the established hospital schools. In September 1960, the eight-hour shift was introduced in the schools of nursing for students. This led to a revision of application forms for entry to the Final Examination by the Council in order to indicate accruals of leave and experiences. The use of these forms for the first time in 1962 revealed clearly the disparity between the requirements of training mandated by the Council and those permitted by the hospital schools. Applications for entry to the Final Nursing

Examination in the year, April 1962, showed that out of 61 applicants only 29 had met the requirements of training as set down by Council. This occurred despite the fact that prior to the final examination an urgent appeal was made by the Council to Matrons of the hospitals to restrict applications for entry to the final examination solely to those complying with the Council's policies.

In order to assist in some measure, students were permitted to write the examination but registration was deferred until deficiencies were remedied. This system of deferred registration continued in use until 1967 when only those who met the requirements as stipulated by Council were admitted to the final qualifying examination. The pass mark was 50 percent in both written and oral parts with an overall aggregate of 55 percent.

By 1966 nurses had replaced medical practitioners in conducting the Hygiene and Public Health aspects of the Preliminary Examination and by 1968, the entire Preliminary Examination was conducted by nurses. In April 1970, nurses were gradually introduced as examiners in Medical Nursing and Surgical Nursing (Beckles, 1985:2-8).

Program Changes

The Nursing Division, in maintaining its close link with the Council, forwarded two reports which received considerable attention--Report of the Basic Education Workshop (1966) and The Quantitative and Qualitative Survey of Nursing Needs and Resources (1968). These gave impetus to the hopes that the Council had since its inception to control in greater measure the training of students for registration. Implementation of the recommendations of those Reports created:

> (a) abolition of the Central Preliminary Training School ...;
>
> (b) shortening of the training period from three years three months to three years;
>
> (c) introduction into the curriculum of training, obstetrics, public health nursing, and psychiatric nursing - three months each;
>
> (d) assumption by the Council of responsibility for the examination held at the end of the first six months of the training program, formerly carried on by the schools; and
>
> (e) agreement in principle on the part of the Ministry of Health that no studentship should continue beyond five years (Beckles, 1985:9).

Implementation was accomplished in phases in the late 1960s and early 1970s with a modification of the three-month experience in obstetrics, psychiatry, and community health to six weeks (Beckles, 1985:7).

Failures in Registration Examinations

The 1970s could be characterized as unsettled and uncertain. There was much dissatisfaction expressed by the Ministry, Schools of Nursing, and the press at the high failure rate in examinations of the

Council. *Statistics over a ten-year period from 1965 to 1975 revealed that there was generally a decline in the pass rate from a high of 89 percent in 1966 to 16 percent by 1975 (Table 1).

During those years, the relationship between the Council and the Ministry of Health on the issue had deteriorated considerably. The Council reported:

> "Requests seeking 4 attempts at the Preliminary and Final Examinations were being received on a regular basis; the Ministry of Health, probably in response to a policy of avoiding student unrest, permitted students to remain in training even though in some cases, these [students] made no attempt to apply for entry to further examinations ..." (p. 10).

The Council was advised by the Ministry of Health that all persons unsuccessful since 1969 (exhausting the five-year period) would be reinstated in order to rewrite the qualifying examination. This, in effect, meant that students who had five unsuccessful attempts were permitted to qualify for another rewrite. The Council petitioned the Prime Minister directly, following which the Ministry of Health agreed to give attention to the regulations which were drafted under the Ordinance of 1960 and had not yet received assent. They were approved on June 30, 1977, 16 years after their submission, as the Nurses and Midwives Regulations, 1977. This was a coup for nursing as the new regulations dictated the number of times a student nurse could write the Preliminary or Final Examinations and

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*Accuracy of data is questionable as three sources, from the Ministry of Health, indicate different percentages. See Table 1 for one source. Regardless of the exact percentage, the concern still holds.

Table 1

Pass Rate in the Nursing Council Final Examinations: 1965-1975

Date	P.O.S.	San F'do	Combined Hospitals
1965	87	76	81.5
1966	100	78	89
1967	97	77	87
1968	86	68	77
1969	77	54	65.5
May 1970	70	58	64
Nov 1970	56	35	45.5
Apr 1971	63	56	59.5
Nov 1971	67	30	48.5
Apr 1972	57	32	44.5
Nov 1972	68	46	57
Apr 1973	24	24	24
Nov 1973	25	26	25.5
May 1974	60	50	55
Nov 1974	41	27	34
May 1975	18	14	16

SOURCE: Evaluation of the Results of the Nursing Council Final Examination of May 1975 in respect of the Port-of-Spain General Hospital School, Ministry of Health, 1975.

"established a Practical Examination to be taken before entry to either the Preliminary or Final Examination, and also established the period over which the various stages of training--Fundamental, Preliminary, and Final--should be completed" (Beckles, 1985:8). Also enshrined was the Council's responsibility for the Fundamental Assessment taken at the end of the first six months of training. All Practical Nursing Examinations were now organized and conducted in the hospitals by the Council (Beckles, 1985:8).

The following outlines the procedures in operations from 1977 for the Certificate in General Nursing or for the Certificate in Psychiatric Nursing.

I. Fundamental Examination

(a) Practical Assessment (25th-26th week of training)

Students were examined in the clinical area on a range of skills identified as basic. Students need not be successful at the practical examination before taking the written part.

(b) Written Examination (27th week of training)

Paper I - Anatomy and Physiology

Paper II - First Aid, Principles and Practice of Nursing

Paper III - Personal and Community Health and Microbiology.

Its aim was to test the student's knowledge of facts. Pass marks were a minimum of 55 percent and students were allowed one chance to resit this examination within one month following publication of the results. Failure at the second attempt led to termination from the program.

II. The Preliminary Examination (15th-18th month of training)

(a) Practical Assessment

This was a similar pattern to that outlined in the fundamental stage with increasingly more complex skills. Students were examined for one hour, usually by the end of the first year, and **must be** successful before proceeding to the written part.

(b) Written Examination

The emphasis was on Anatomy and Physiology with attempts to integrate knowledge of First Aid, related Nursing, Microbiology, Personal and Community Health, Psychology, and Sociology applied to nursing.

Opportunity was provided for one resit. Failure at the second attempt led to withdrawal.

III. The Final (or Qualifying) Examination (end of three years)

(a) Practical

Part A - Aseptic Techniques, Administration of Medicines

Part B - Care of the very ill patient, Ward Administration.

Part A had to be successfully completed before attempting Part B, and the latter had to be successfully completed before an attempt at the theoretical part of the examination. At that stage, the content of the examination in General and Psychiatric Nursing differed for each group. Students were notified of the results of the examination through sealed envelopes via the Matron of the Hospital. Two resit opportunities were permitted. A student was expected to qualify for admission to the Register by passing the final examination by the end of five years from the date of entry to the program. Failure to comply with this regulation resulted in the removal of the student's name from the Register of Student Nurses (Seminar on Clinical Evaluation, 1985).

Staff Preparation for Student Examinations

The Council in executing its mandate continually sought to refine the educational and examination procedures and processes for nursing students. Just about the time that the Regulations of 1977 received assent, the Council requested assistance, from the School of Education, UWI, in training personnel involved in nursing education. The intent was to improve the competence of staff responsible for assessing practicals on the hospital wards, and for setting and monitoring written examinations in the Theory and Practice of Nursing. Planning for the workshop revealed that the problem of assessment existed much earlier in the teaching-learning process than evaluation, and that there was insufficient joint planning and dialogue between the staff of the nursing schools and the supervisory personnel on the wards which led to a lack of coordination in the teaching-learning activities in both settings.

The program was conducted over nine weeks with participants attending one day a week. The participants felt confident on completion of the course that they would be able to improve communication between classroom teachers and trained ward staff, and recommended that all examiners and assessors should be exposed to similar workshops (Gift, 1979). A further seminar was held, in May

1985, on Clinical Evaluation for Nurse-Examiners under the Council's auspices. The purpose was to assist participants in providing a unified approach to evaluation of the student's total learning experiences. The intensive three-day seminar afforded participants opportunity to gain further knowledge of the curriculum, its contents, process, and methods of evaluation (Seminar on Clinical Evaluation, 1985:2).

It was clear that the Council had assumed a leadership role in its attempt to maintain standards of quality in nursing education. Members, however, were very sensitive to and very conscious of the powerful role that the Ministry of Health exercised in nursing education. This is evidenced in this statement:

> ... CNO, with the politicians at the Ministry, decide on the standards, and tend to be seen as not standing up for nursing. The question of allegiance was raised as to the role of nursing at the Ministry--whether it was to the profession or to the civil service and politicians. There is an erosion of independent thinking over the years. Government is the source of economic, political and social advancement for the people ... (Interview, January 1986).

While the Nursing Council, by law, had a large measure of control over the education and practice of nursing, it was obvious, however, that it was not the major agency concerned with nursing education in the post-colonial era. The Nursing Division, Ministry of Health, played a key role in both the education and the practice of nurses. To that area we will now turn.

E. The Nursing Division

The Ministry of Health exercised its role in nursing education primarily through its Nursing Division. Since the early 1940s, two posts were created in the Health Department, a Nursing Superintendent (Curative) to deal with nursing matters in the institutional services and a Supervisor, Public Health Nursing to deal with nursing matters in the Public Health Services. In 1959, the decision was made to create a post of Principal Nursing Officer which had been suggested at the Fifth Caribbean Medical Conference and supported in the Houghton Report (1953). Its intent was to coordinate the various branches of nursing and to advise on training and allied matters. The post was formally created in 1960 but remained vacant until 1969 when Violet Lines, Nursing Superintendent (Curative), was promoted to the position.

In 1966, two events of significance to nursing took place. The first was that nurses became a part of the Public Service Association. Re-organization of the Civil Service occurred in 1960-61, attendant upon the Julien Commission Report (1957) and the Lee Report (1959), and further the Civil Service Report (1964) had pointed out the unsatisfactory conditions that obtained in nursing. Consequently, the Public Service Association "fought for nurses to become a part of and considered as civil servants. They played a critical role in the conditions of service" (Interview, January 10, 1986). Nurses and student nurses were now members of the union--The Public Service Association. The second event of significance was the creation of a Nursing Division.

The stated objective was "to deliver to individuals, families, and groups, a comprehensive care, adequate in quantity, up-to-date in quality and commensurate with the aspirations and resources of the country" (Lines Report, 1969:2). The Division consisted of the Office of the Principal Nursing Officer, Nursing Superintendent (Curative), the Director, and Assistant Director of Public Health Nursing, with the latter responsible for Nursing Education in the country. The principal functions of the "central command" were seen as policy definition, program formulation, and direction. Its main purpose was to be the development, evaluation, and up-dating of nursing norms and standards and field supervision of the Nursing Services. It, however, three years later, had not assumed the role outlined in the Health Plan and was overburdened by executive responsibilities traditionally assigned to its directive team (Lines Report, 1969:5). Consequently, in 1969, the Minister of Health appointed a committee with the assistance of a PAHO/WHO consultant to conduct an Organization and Methods Study of the Administration of the Nursing Division. Emanating from the Report were 18 recommendations ranging from the need for policy formulation to the development of written procedures. The necessity for the Nursing Division to maintain and improve standards of nursing education and performance, and promote research into nursing matters was a point of emphasis (1969:21-24). In an attempt to streamline activities, the position of Director of Nursing Education was created in 1971, and the position of Assistant Director of Public Health Nursing became redundant (Interview, January 10, 1986). These positions remained essentially the same over the years with cosmetic changes in titles only. In 1986, the Division comprised the Chief Nursing Officer (former title: Principal Nursing Officer), the Director of Nursing Education, the Director of Institutional Nursing, and the Director of Community Nursing.

The Chief Nursing Officer who headed the Nursing Division advised the Chief Medical Officer on policies, programs, and human and physical resources related to nursing. She also participated in health care planning and program formulation. The Director of Nursing Education was responsible for the development of all basic and post-basic nursing education programs, as well as staff development programs for graduate nurses, and the interpretation of policy matters to senior nursing personnel. ~~The Dire~~ctor of Institutional Nursing advised the Principal Nursing Officer on all matters pertaining to Institutional Nursing Services, and was responsible for the improvement of the quality and quantity of nursing care. In addition, she assisted the nursing administrators with policies concerned with recruitment, selection, and deployment of nursing personnel. The Director of Community Health Nursing was responsible for Community Health Nursing in collaboration with her medical counterpart in Community Health Services. She was held accountable for monitoring standards and maintaining quality of care in the 102 health centers and eight delivery units (PNO Report, n.d.:1-7).

Just prior to and since the inception of the Division, several circumstances transpired in the health services which affected the training of nurses.

Manpower Shortage and the Brain Drain

During the 1960s, with hospital expansion, clinical and preventive services, the efforts to provide a satisfactory health service could not keep pace with the rate of population growth. The problem of demand and supply of doctors and nurses experienced in earlier years continued to plague the Ministry (Foster, n.d.). Short-term solutions such as the recruitment of West Indian nurses from the United Kingdom had been suggested in the Civil Service Report (1964). Thus, in 1966, the government went on a special mission to the United Kingdom to induce its nationals to return home but the results were disappointing (Chan, 1975:26). Superimposed on the problem of shortage of staff was that of the brain drain. The problem of the brain drain, a modern day phenomenon, was concerned with three types of situations, namely, nurses who went abroad to take a better job than they had or than was in prospect in the country, those who went abroad for training without intending to return, or who intended to return but did not, and finally, the inability of the system to effectively utilize the skills, knowledge, and expertise of those with advanced preparation.

The exodus of nurses to Canada and the United States peaked between the period of 1966-1969 to a total of 1,243 endorsments given by the Nursing Council. While endorsement of registration forwarded by the Nursing Council on behalf of a nurse to an overseas registering agency is by no means an accurate index of corresponding departure from the territory for overseas practice, endorsements serve to indicate migration trends of registered personnel (Nursing Council, 1976). In medicine, the brain drain was not only extra-regional but intra-regional, in that, instead of returning to their home country, graduates from the smaller territories as well as Guyana and British Honduras often took employment in Trinidad and Tobago as well as Jamaica where units of the UWI were situated (CHMC, 1969:87).

The government recognized that the loss of skilled manpower needed to be stemmed if investments in education and training were to bear returns. Accordingly, they posited that appropriate salaries and satisfactory working conditions, in which specialized skills could be exercised with initiative, would have to be provided, and that recruitment procedures would have to be more expeditious and flexible in the public sector (DP III, 1970:101). A major factor which contributed to the brain drain in nursing, as well, related to procedures utilized by the Personnel Department of the Civil Service. Entry to the Civil Service was at the lowest "rung," so that nationals returning with degrees were not placed in positions they expected. There were rarely exceptions to this rule. An interviewee cited a recent situation:

> ... [she] came from Britain and had experience as an administrator for 2 years--she took up a staff nurse position and then moved on to administration at Mount Hope. They have to come in and start at a staff nurse level. This is one of the chief reasons that returning nationals return (to the metropolitan countries) ... (March 4, 1986).

Yet another remarked:

> ... It is impossible to get to the top without going up the ladder in a senior position in the hospital--you will be torn down (January 9, 1986).

The issue was of concern regionally as well. At the First Conference of the Caribbean Health Ministers in 1969, the topic of Brain Drain was addressed. Many recommendations were put forward. It was urged that governments should give consideration to providing special housing loans for professional groups in short supply and should try to "speed up the machinery for appointments and promotions in all branches of medical and paramedical services" (p. 8). Specifically, for nursing, it was suggested that steps needed to be taken to make the nurse have the feeling that she was making a worthwhile contribution to the well-being and progress of her community through payment of an adequate salary; further, "that praise from higher authority and the granting of prestige [were] the most potent weapons of all towards promoting higher morale and retaining the best workers in the service" (CHMC, 1969:87). Yet the problem was never solved. Moreover, at a time of shortage, there were recruiting agents from the metropolitan countries. Chan (1975) expressed astonishment at this situation. He pointed out that they were "offering blandishment, especially to trained nurses to go abroad--which seemed so unnecessary!" (p. 26).

Impact of Regional and Local Studies

Several events transpired regionally and locally which were fortuitous for nursing. One was the Third Regional Nursing Seminar in 1966 in Jamaica at which the issue of manpower for the territories was discussed. It was recommended that surveys of nursing services be carried out in each territory in order to assess the resources and needs, and to provide a basis for the preparation of appropriate educational programs (1966:20). Another was the Regional Survey and Re-Survey of the Schools of Nursing in the territories conducted by PAHO which led to curriculum changes. The third event was the First National Health Plan which was in the process of development and proposals for strengthening the nursing complement were formulated (NHP, 1967:76).

The newly-created Nursing Division took the initiative, as its first task, to conduct a Qualitative and Quantitative Survey of nursing needs and resources (Q and Q Survey, 1968). This project was undertaken in 1966 by the Ministry of Health in collaboration with PAHO/WHO. The purpose was to develop a rational plan to meet the increasing health service needs of the country. Max Awon, the Minister of Health, remarked:

> ... The Nursing profession of this Country is to be complimented for its foresight in having pioneered, ahead of all professional groups, a comprehensive study of its needs and resources and for having produced a well-conceived Ten-Year Plan commensurate with the policies and capabilities of the Nation .... Its findings are important to the more efficient operation of the health services and these have been taken into consideration in the country's first National Health Plan ... (Q and Q Survey, 1968, Foreword).

The Survey (1968) conducted by the three nursing officers of the Ministry of Health and PAHO/WHO Nursing Advisor enabled them to look into the strengths and weaknesses of nursing manpower resources. An inventory was taken of all persons within the nursing profession; the workload output, distribution, and preparation of these resources were studied. As a result of the findings, a ten-year plan accompanied by a program for each field of nursing was formulated, including plans for the development of a nursing assistant program.

Program Changes

While the need for embarking upon a plan to introduce a new system of administering and financing the basic nursing education programs was demonstrated by the Survey, efforts had been continuing to improve on the training of nurses. In 1960, a Central Preliminary Training School (CPTS) was constructed in San Fernando and there were revisions made in the students' training. New recruits admitted to the three teaching hospitals, Port-of-Spain, San Fernando, and St. Ann's, now spent the first three months at the CPTS studying from a broadened syllabus at the end of which an examination was held, and successful candidates would then be considered as student nurses at the three hospitals. The "block" system was now fully established in which students spent the following time: In the first year, four to six weeks were spent in the classroom, with 43 to 45 weeks in clinical practice on the wards and vacation time of three weeks. In the second year, classroom time was six to ten weeks, with clinical practice of 39 to 43 weeks and vacation of three weeks. By the third year, classroom time was four to ten weeks with clinical practice of 38 to 44 weeks and four weeks vacation. Over the three-year training period, students spent approximately 18 to 22 weeks (12 to 15 percent) in the classroom and 124 to 128 weeks (85 to 88 percent) in the practice area (Q and Q Survey, 1968:24). This was apart from the theoretical content taught at the CPTS. Thus at the end of the three-year three-month program, seven months would have been full-time planned classroom activities with lectures from doctors and Sister Tutors. The evaluation of students' practice was conducted in the clinical area by the nurses on the wards with the aid of guidelines and assessment tools. A final Hospital Assessment which consisted of both theory and practical components was the only examination conducted by the school (Holford, 1985). Figure 6 depicts the curriculum as it obtained in 1962.

By 1964, the PAHO Survey of Schools of Nursing (1966), the first stage of which was completed, led to changes in the curriculum. The Ministry of Health in conjunction with the PAHO Nursing Consultant initiated the first Basic Nursing Education Workshop in January 1966 at the Port-of-Spain Hospital School of Nursing. Its aim was to prepare the revised curriculum in which students could give comprehensive care based on the recommendations of the Report. Bryce-Boodoo (1975:34) observed that "for the first time in the history of nursing all grades of nurses were able to contribute." What evolved from this workshop was the "burning desire for In-Service

Figure 6

Nursing Syllabus [Curriculum] 1962
Length of Training: 3 Years and 3 Months

Subjects	Number of Lectures	Lecturers
FIRST YEAR PRELIMINARY EXAMINATION PART I		
Anatomy and Physiology	40	Registered Medical Practitioner or Sister Tutor
Hygiene and Public Health	24	Registered Medical Practitioner with Diploma in Public Health or Sister Tutor or Health Visitor or Experienced Visitor
PRELIMINARY EXAMINATION PART II		
First Aid	10	Registered Medical Practitioner or Sister Tutor
Bacteriology and Principles of Aseptic	6	Lecturer in Bacteriology or Sister Tutor
Principles and Practice of Nursing		Sister Tutor, Departmental Sister or Ward Sister
Invalid Cookery		Qualified Dietitian or Sister Tutor
Psychology	36	Lecturers in Psychology or Psychiatry and Sister Tutor
FINAL EXAMINATION		
General and Special Nursing Procedures	30	Sister Tutor or Departmental Sister or Ward Sister
Medicine and Medical Nursing	40	Registered Medical Practitioner and Sister Tutor
Surgery and Surgical Nursing	40	Registered Medical Practitioner preferably with (F.R.C.S.) and Sister Tutor
Gynaecology and Gynaecological Nursing	6	Specialist Lecturer
Genito Urinary Nursing	6	Specialist Lecturer
Paediatric Nursing	6	Specialist Lecturer
Materia Medica	10	Qualified Pharmacologist
Radiotherapy		Specialist Lecturer
Physiotherapy	2	Specialist Lecturer
Occupational Therapy		Specialist Lecturer
Psychotherapy	2	Specialist Lecturer
Social Aspects of Disease	4	Specialist Lecturer

CLINICAL EXPERIENCE is available in the following wards and departments:

1. Surgical
   - Aseptic
   - Septic Male and Female
   - Gynaecological
   - Neurosurgical
2. Orthopaedic
   - Male
   - Female
3. Paediatric
   - Surgical
   - Medical
4. Medical Wards
5. Operating Theatre
6. Ear, Nose and Throat Department
7. Eye Department
8. Casualty
9. Out Patients Department
10. Radiotherapy
11. Physiotherapy
12. Diet and Milk Kitchens

HOSPITAL SCHOOLS BLOCK

4 weeks before Preliminary Examination Part I
4 weeks before Preliminary Examination Part 2
6 weeks during second year to commence 6 months after passing Preliminary Examination Part 2. Lecturers to continue until syllabus completed
4 weeks before the Final Examination

SOURCE: History of Nursing Education in Trinidad and Tobago 1822-1962, Unpublished document, by Lucy Fields, N.D.

Courses" to prepare registered nurses to supervise students along modern concepts of nursing practice, and the need for training auxiliary nursing personnel (Bryce-Boodoo, 1975:34). This acknowledgement of the short-comings in the adequacy of student supervision was recognized in both the Regional and Local Surveys. Moreover, the teacher-student ratio was very high ranging from 1:37 to 1:57, and there was a limited number of prepared teaching staff. Of 34 nurses engaged in teaching activities in 1966, only eight had teaching preparation (Q and Q Survey, 1968:7; 25).

Following these Surveys, there were definite efforts at making changes. By 1967, the CPTS was discontinued as students had difficulty in adjusting to the hospital environment because of the limited clinical exposure during those three months, and in 1969, the new curriculum which geared students to give comprehensive nursing care was implemented. Students now received instruction in all aspects of nursing including obstetrical and psychiatric nursing for six weeks (Bryce-Boodoo, (1975:34); Interview, January 10, 1986). Despite those significant attempts to improve on the curriculum, the Regional Re-Survey of Schools of Nursing in 1970 revealed that, while the San Fernando School had met the criteria, the Port-of-Spain School had only done so partially. This led to the development of workshops and in-service programs to assist nurses in supervising on the wards, and nurses were sent on scholarships to UWI to take the Advanced Nursing Certificate program while one nurse went to Canada (Interview, January 10, 1986).

Further, the Nursing Division developed a plan which, if it had been implemented, would have introduced a fundamental and radical change in the system of nursing education in the island. The plan proposed a separation of nursing education from nursing service. This concept, articulated in the Q and Q Survey (1968), was then in vogue in both Canada and the United States. Several studies since the 1930s in the metropolitan countries had advocated that nursing education be transferred from the jurisdiction of hospitals to that of educational institutions.* While many had done so in the United States, in Canada the issue was yet, in the late 1960s and 1970s, heated and controversial with only one or two pioneering attempts. The plan proposed by the Nursing Division was thorough, including the financial implications with a scheme of awarding scholarships, on request, to nursing students desiring financial aid. While the Minister of Health supported the Plan, it did not get Cabinet Approval (Nursing Education Plan, 1970). This response was not unexpected as much resistance occurred, and was then still occurring, in the metropolitan countries from governmental, medical, and hospital services with regard to the transfer of nursing education.

In the meantime, there was significant nursing input into the National Health Plan which was being formulated. Nursing ensured that the concern for strengthening the nursing manpower was included in the Plan through the introduction of nursing assistants. Since 1957, various committees and reports (First Regional Nursing Seminar, 1965; Nursing Education Committee, 1957; Q and Q Survey, 1968) had suggested the use of this health care team member. It was finally effected in 1968.

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* See Goldmark, Josephine, Secretary. Nursing and Nursing Education in the United States. New York: The MacMillan Co., 1923; Mussallem, H.K. Nursing Education in Canada. Ottawa: Queen's Printer, 1965; Committee for the Study of Nursing Education. Weir, George M. Survey of Nursing Education in Canada. Toronto: University of Toronto Press, 1932.

Student Attrition and Examination Failures

Meanwhile, coupled with staff shortage and facilities expansion, there was increasing student attrition from failures in the Final Registration Examinations during the years 1968 to 1970. Additionally, many prospective students were also failing the Council's Entrance Examination (Interview, January 10, 1986). These two factors compounded the manpower problem precipitating two detailed reports, by the Principal Nursing Officer dated June 18, 1970, and the Nursing Superintendent (Curative) dated October 16, 1970, into the causes of the high failure rate and attrition in the basic nursing programs. Table 2 indicates another source* with regard to the percentage of students who passed the Council's Final Examination between 1965-1970.

Attrition in the program was inversely proportional to the degree of educational attainment in that two-thirds (2/3) of the drop-outs

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* See Table 1, page 151.

Table 2

Percentage of Basic Nursing Students Passing Nursing Council Examinations: 1965-1969 (Date of Study: June 1970)

SCHOOL	Preliminary Part I						Preliminary Part II						Final					
	1965	1966	1967	1968	1969	Average	1965	1966	1967	1968	1969	Average	1965	1966	1967	1968	1969	Average
Port-of-Spain	57	50	58	74	52	57	97	97	99	100	93	97	69	81	83	54	49	68
San Fernando	63	66	63	69	52	61	99	100	85	96	96	95	68	78	76	68	54	69
St. Ann's	58	70	62	60	41	61	89	98	93	95	95	95	49	50	56	95	47	64
COUNTRY	59	60	61	68	51	59	97	98	92	97	95	96	65	74	77	70	51	68

SOURCE: Nursing Council of Trinidad and Tobago, Principal Nursing Officer's Report, June 18, 1970, Ministry of Health, Port-of-Spain, Trinidad.

were students with Primary School Education. Since students with one to four GCE passes appeared to contain the most stable students, the Principal Nursing Officer advised directing future recruitment efforts towards enlarging the intake of that group with a corresponding decrease in the lower educational group (PNO, 1970:3). The high failure rate was due to a multiplicity of factors apart from the inadequacy of educational background. The new comprehensive curriculum with its inclusion of psychiatry, obstetrics, and community nursing within the three years of the program limited the students' experience in general nursing leading to inadequate preparation. Student-teacher ratio, library and hostel facilities, equipment, supplies, staff preparation were all found to be wanting in previous reports. Since students were Public Service employees it was considered desirable, among the recommendations, to raise the entry requirements from Primary School Leaving Certificate to that required of all Public Service employees, namely, five GCE passes (The Fields Report, 1970).

In 1975, five years after these reports, no action had been taken on any front. The problem increased and with results at an all-time low--84 percent national failure rate (Nursing Council, 1975)--further investigations were precipitated. An analysis of the results of the Final Examination was conducted by a statistician in the Ministry of Health. Because the sample was small (83 students) results were interpreted with reserve. The tentative conclusions, nonetheless, indicated that:

1) Marriage [had] the effect of lowering the student's

> probability of passing ...
>
> 2) By raising the entrance requirements the failure rate would decline ...
>
> 3) ... the major reason for the low pass rate was either the poor organization of the course or the examination situation or both ... (Ministry of Health, May 1975).

Several reports over the years had addressed this issue of student failure (Cabinet Committee relating to Results, 1966-1970; PNO Report [1970]; Re-Survey of Schools of Nursing PAHO/WHO, 1971; Survey of Schools of Nursing PAHO/WHO, 1966; The Fields Report [1970]). Lucy Fields, Nursing Superintendent (Curative) was again assigned the task of investigating the educational program by the Ministry of Health. Fields was unequivocal in her report. She responded:

> ... I was one of the 24 members of the [Cabinet] Committee, there were six sub-committees and I was a member of Committees 1, 3, 4, and 5. Recommendations made by this Cabinet Committee covered every aspect of my present assignment .... It would seem that quite a lot of work has been done by PAHO/WHO and the Ministry of Health in an effort to improve nursing education and Nursing Service in the country but for one reason or another not much action has taken place as shown by recommendations which have not been implemented (1975:3).

The comprehensive Report with its sweeping recommendations was followed by the appointment of yet another Committee "To consider the findings of all previous reports in light of the high failure rate and to make recommendations" (Beaubrun, 1975). This committee had broad representation of senior medical and nursing representatives from the Ministry of Health, the three teaching hospitals, the Nursing Council, and the Student Nurses' Association. The findings, nonetheless, did not differ substantially from previous reports. The same deficiencies of the schools and hospitals were identified. There was no area left untouched. The 34 recommendations covered administration of the schools, ward teaching, in-service training, nursing instructors, recruitment, curriculum, examinations, interpersonal relationships, counselling, night duty, and affiliate experiences.

Two years later, in 1977, entrance requirements were raised to 5 GCE "0" level subjects of which Mathematics and English were compulsory. Not unexpectedly a decline in enrolment followed this action. While decreased enrolment may have helped temporarily nurse educators who had been requesting reduction in numbers in order to properly supervise students, it did not solve the problem of a high teacher-student ratio as the complement of instructors remained the same. This was an observation in the Q and Q Survey (1980:30) which found that the teacher-student ratio in 1980 was 1:14. While this was a significant improvement since the last survey, it was however, merely a reflection of decreased enrolment and not an accurate picture of teacher-student ratio.

Further, a smaller student enrolment exacerbated the problem of staff shortage. Thus, in March 1979, Cabinet appointed a Commission to enquire into the entry requirements for the nursing profession. The Commission identified two causes for the decrease in student intake:

(a) The change from four to five passes at the GCE "0" Level instituted in 1977; and

(b) the existence of two serious weaknesses in the system of recruitment

> (i) too much time is allowed to elapse between the annual publication of the GCE results and the commencement of recruitment of nursing students; and
>
> (ii) the interval between application and acceptance was found to be inordinately long (cited in Q and Q Survey, 1980:29).

A reduction in entry requirements to four passes at the GCE "O" level was recommended. It was clear that action had been taken and that it was effective because from 1982 there was an increase in enrolment which was the intent of the recommendation. One interviewee recalled, "... we had a high attrition rate and we could not get sufficient recruits, and few graduates so that the politicians stated that we must have large intakes of about 100." Enrolment, however, never reached that limit but it did increase to 80 twice a year without a corresponding increase in staff (Interview, January 10, 1986).

Student Enrolment and the Selection Process

The number of students admitted any given year fluctuated and was determined by the budget allocation through the Ministry of Finance. Intakes were generally twice annually at any point in time with one intake some years. The numbers admitted varied dependent on recruitment, attrition, staff shortage, and health facilities expansion to a maximum of 822 total enrolment in the three schools of nursing as outlined in the National Health Plan 1967-76. This was adhered to a decade later despite the completion of a new modern 320-bed medical complex.

Selection of students was determined by a panel which comprised two representatives from the Ministry of Health--The Chief Nursing Officer and the Director of Nursing Education, a representative from the Nursing Council, the Principal of the School, and the Matron of the Hospital. The process to be admitted to a nursing school was a lengthy process. This was a criticism of both the Morean Committee (1979) and the Q and Q Survey (1980). After the screening of prospective candidates by the Nursing Council to determine academic requirements, those who met the requirements were interviewed by the Matron of the Hospital. The educational and age requirements (17 to 35 years) already approved by Council were re-examined together with other documents such as certificate of marriage and testimonials from priests, school teachers or others attesting to the candidate's good character. The candidate then waited to be called before the Selection Panel which met once or twice a year. The aim here was to weed out those who might have psycho-social problems. Those who were judged by the Panel to be suitable candidates were notified by the Matron of the Hospital to report for a Medical Examination. The final step in the process was a visit to the School of Nursing to receive orientation for entry into the School (Q and Q Survey, 1980:28-29). This inordinately long procedure probably had deterrent effects on the recruitment of potential students as well.

By the 1970s with the greater emphasis in the health care system on the prevention of illness, health care delivery had increased in the homes, community, and industry. With these changes the scope of nursing had expanded in coverage and substance. Moreover, in addition to student attrition and decreased enrolment, nurses continued to migrate to the metropolitan countries even though in significantly less numbers than in the 1960s. Between 1971-76, 980 applications for endorsement were processed by the Council for nurses seeking registration abroad (Nursing Council, 1976). It was evident that manpower problems continued to plague the Ministry despite the use of nursing assistants. When the nursing manpower survey was conducted in 1966 it called for a periodic reassessment of resources. Consequently, in 1975, a Committee was appointed under the chairmanship of the Acting Health Planning Officer, Ministry of Health, to examine and make recommendations concerning nursing manpower. To arrive at manpower needs, the Committee applied the same formula used in the Q and Q Survey (1960) to assess the adequacy of the nursing care delivered and they advised the recruitment of nurses from abroad (Foster, n.d.). As the nation's economy was buoyant at that time, 500 nurses trained abroad were recruited to serve the country (Foster, n.d.; Q and Q Survey, 1980).

Meanwhile, the Nursing Division had directed its attention to three major activities:

(1) The development of a curriculum in the basic nursing program;

(2) Developing the managerial and clinical skills of nursing staff; and

(3) Long-range manpower planning.

Curriculum Development

In 1976, nursing educators and the then Director of Nursing Education, Valerie Foster,* expressed the need for a new curriculum. Through her initiative a Core Committee was formed to develop a curriculum using as a basis the Nursing Council's Syllabus of Subjects for the Certificate in General Nursing (Holford, 1985). The previous curriculum which identified topics and courses was limited in scope and was geared towards the curative aspects of health care. Further, the changing face of health care demanded that emphasis be placed on the preventive aspects of health care (Taitt, 1985:3). The framework for the curriculum followed the broad guidelines which were developed at the Third Seminar on Nursing Education in Jamaica in 1966 (Interview, Juanuary 17, 1986).

International, national, and professional influences had their impact on the curriculum. On the international scene, the WHO Expert Committee on Community Health which met in Geneva in 1974 to discuss community services promoted the concept of Primary Health Care. Its aim was to provide for the basic health needs of individuals at a safe and acceptable level in their own communities. Implementation of this approach required a change in the education of nurses to prepare them to be generalists capable of functioning in any health care setting (Brewster, 1985:2).

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*Became Principal Nursing Officer in 1984, and with a title change in 1986 to Chief Nursing Officer.

Nationally, with the gradual shift in emphasis from a curative focus to preventive measures, health care delivery had increased in the homes and community. Additionally, the government in 1978, was signatory, at the Alma Ata Primary Health Care Conference, to the goal of "Health for All by the Year 2000" with subsequent future construction and expansion of primary health care centers. Thus, one of the first tasks of the Committee was an identification of the health problems and needs of the population. This involved studying the services and agencies available for meeting health needs; identifying the purpose, philosophy, and organizational structures of the teaching hospitals; identifying the characteristics of students and teachers; and searching the population and health statistics for indicators of morbidity and mortality. Their findings revealed that 60 percent of the population were under 25 years; that there was an increasing incidence of mental health problems, and that major health problems were cardiovascular diseases, diabetes mellitus, neoplasms, accident, and suicides. Moreover, these health problems were mainly with individuals in the community who received little care (Brewster, 1985:3).

In the professional sphere, the trends in nursing in metropolitan countries increasingly used the nursing process as the instrument through which care was given (Brewster, 1985:3-5).

Consequently, changes were incorporated in the new curriculum to reflect those international, national, and professional concerns. The Committee met for three years during 1976 to 1979, with the assistance of PAHO/WHO Consultant, Una Reid, a West Indian, who guided the development of the curriculum, which was patterned on a North American model. There were, however, unique features such as a greater focus on primary health care (Interview, January 17, 1986). Further indigenous features related to social and health service problems, such as a lack of public utilities and recreational facilities, that affected the population, the concept of work and attitudes towards same and other cultural factors and beliefs. Particularly outstanding was its many references by Caribbean authors bringing a regional flavor to analysis of issues (Curriculum, 1982). The new curriculum was a thorough and comprehensive document. It outlined in great detail the philosophy of nursing education, its conceptual framework, curriculum objectives, and a list of courses with detailed behavioral objectives.

On completion of the new curriculum geared to the future preparation of nurses, it was submitted to the Council for study. The curriculum was accepted with some minor changes to facilitate the holding of the three Nursing Examinations of the Council over the three-year training period (Curriculum, 1982).

The schools developed and implemented areas of the curriculum with groups of students since 1976. Implementation in full occurred in 1980 and 1981 at the Port-of-Spain School of Nursing with a partial review of content in 1982 (Interview, February 3, 1986). Because the

Schools did not have complete control of the students' learning experiences, whenever there was a shortage of staff, students were moved from one unit to another. This necessitated adjustments in the students' learning experiences during their elective period which was a novel feature in the newly designed curriculum. Service needs, however, continued to take precedence over students' learning experiences leading to "a discrepancy between what we have in the curriculum and what obtains in practice" (Interview, January 21, 1986). Despite these concerns, it was the first time in the history of nursing education in the nation that such a thorough document was available for use by all concerned with the education of nursing students.

Much pride and excitement seemed to be generated by its use. Notwithstanding this major undertaking over three years, there remained the expectation that in the not-too-distant future students would enjoy student status instead of being Public Service employees. Figure 7 shows a comparison of the curriculum as it obtained in 1913, 1962, and 1981, when significant program changes were effected.

Students as Civil Servants

The fact that all nurses and nursing students were Civil Servants and members of the Public Service Association was a source of much conflict for the profession. It had direct consequences on nursing education and was both a strength and weakness for nursing. On the one hand, being a Civil Servant afforded many advantages. It provided

Figure 7

Comparison of Nursing: 1913, 1962, 1986 Nursing Curriculum

1913

Length of Training:
3 Years

Subjects	Number of Lectures
1st Year	
Elements of Nursing	12
Elementary Anatomy and Physiology	12
Demonstrations on Ward Work	6
2nd Year	
Surgical Ward Work	12
Properties and Dosage of Drugs	6
Advanced Physiology	12
3rd Year	
Advanced Anatomy	12
Medical Nursing	6
Gynaecological Nursing	6
Care of Infants	6

1962

Length of Training:
3 Years and 3 Months

Subjects	Number of Lectures
First Year Preliminary Examination Part I	
Anatomy and Physiology	40
Hygiene and Public Health	24
Preliminary Examination Part II	
First Aid	10
Bacteriology and Principles of Aseptic	6
Principles and Practice of Nursing	
Invalid Cookery	
Psychology	36
Final Examination	
General and Special Nursing Procedures	30
Medicine and Medical Nursing	40
Surgery and Surgical Nursing	40
Gynaecology and Gynaecological Nursing	6
Genito Urinary Nursing	6
Paediatric Nursing	6
Materia Medica	10
Radiotherapy	
Physiotherapy	2
Occupational Therapy	
Psychotherapy	2
Social Aspects of Disease	4

1986

Length of Training:
3 Years

	Allocation of Hours				
	Theory	Clinical Experience			Total
		Ward	Community	Psychiatry	
Year One					
Nursing 100 Well Individual and Family	143	-	130	-	273
Nursing 101 Profession of Nursing	43	-	-	-	43
*Nursing 102 The Expanding Family	*215	234	333	97-1/2	879-1/2
Anatomy and Physiology (Structure and Function of the Human Body)	156	-	-	-	156
Psychology (Introduction of the Individual Human Behaviour)	55	-	-	-	55
Sociology (Introduction to Human Behaviour in Groups)	35	-	-	-	35
Microbiology Applied to Nursing	45	-	-	-	45
First Aid	30	-	-	-	30
Pharmacology Applied to Nursing	32	-	-	-	32
*Pathophysiology	*110	-	-	-	110
*Nutrition - Part I	* 80	-	-	-	80
Year Two					
*Nursing 102 The Expanding Family	* -	-	-	-	-
Nursing 103 The Growing Family	245	265	265	265	1040
*Pathophysiology	* -	* -	* -	* -	* -
*Nutrition - Part II	* -	-	-	-	-
Year Three					
Nursing 104 The Beginning Family	115	152	303	-	570
Nursing 105 The Contracting Family	65	205	205	205	680
Nursing 106 Professional Development	80	106	106	106	398
*Nutrition - Part II	* -	-	-	-	-
Clinical Elective					
Totals	1449	962	1342	673	4426-1/2

* The total hours for these courses are spread throughout the curriculum.

job and financial security, and many "perks" such as government scholarships for post-graduate studies solely tenable by Civil Servants, a good pension plan, union protection, and facilitated the entry into nursing of many applicants from the poorer areas of the country who, otherwise, would not have been able to afford to be nurses (Interview, January 9, 1986). On the other hand, being a Civil Servant was disadvantageous to nursing as a profession. The regulations and procedures of the Public Service Commission particularly with regard to promotion to senior positions were criticized by many interviewees. Some comments were:

> Being in a Civil Service--merit is not rewarded but length of service-- ... going to do a further course is no guarantee of a higher position or more salary. It may, in fact, work against you ... seniority ... is strong here, no matter how much qualifications you return with, if in a department the person is senior to you, you just grin and bear it and function at a lower level, in terms of administration. We hope that the wisdom of those who are deciding will make them ignore length of service and use education and experience. I feel if the present Minister continues in office there will be a wind of change. He wants to make health an industry with managers--nurse managers; I am hopeful! (Interview, January 16, 1986).

> Seniority is a factor that is taken into consideration .... Before, we wanted to appoint senior people--those who were nice to us--but this is changing. Positions are being advertised now in the open and interview panels are being set up to interview candidates. The panels should not be biased otherwise there would be no change. The Head of the organization--the senior people must be committed to change otherwise you are not going to get any facilitation for change .... There have been efforts on the part of this Minister and the Permanent Secretary to break this chain and establish new systems ... (Interview, February 20, 1986).

> It is important in a small island like Trinidad and Tobago that we do acknowledge and respect those of our sisters that have gone abroad and got new ideas, and give them the chance to put some of those into operation ... It rests with the Public Service Commission ... the procedure is faulty--no interviews--and it does not give the opportunity for some of the new blood to jump

> ahead .... I think we should open positions up and look at people in education, administration, hospital, and community services ... consider the best of the crop and not just the top 20 people who are eligible (Interview, March 4, 1986).

The findings of the Q and Q Survey (1980) indicated that nursing achievements were often overshadowed by a lack of enthusiasm. The low morale, and, at times, despair were attributed to several factors. Among them were:

> the system under which the appointment and promotion of personnel are decided on the basis of seniority, instead of screening a candidate in terms of intelligence, academic qualification, and ability required to perform the job; and in the lack of opportunities towards which better qualified nurses could project their aspirations, and the unjustifiable low scale on which nursing posts are classified on the Civil Service ladder ... (p. 64).

Another disadvantage to civil servant status related to the area of discipline which was governed by the Public Service Association's procedures. These were not only cumbersome but created managerial and educational paralysis in taking disciplinary action with respect to either staff or students. One interviewee remarked:

> ... It is a breakdown on who are civil servants, who are students--students are civil servants. Because disciplinary measures are not in place for staff, people are afraid to take disciplinary measures because they often feel as the disciplined one ... (Interview, January 24, 1986).

Another:

> ... You do not have many disciplinary tools and avenues to use, added to which as soon as you start to think of disciplinary measures; it is the same association that represents all levels and the machinery is so slow to get anything done ... (Interview, January 17, 1986).

As well, the influence of the union has been attributed to the decline in the attitude of nurses and nursing students with regard to discipline and the work ethic (Interview, January 31, 1986).

Linked to this status of students as civil servants was the question of salaried students. The further dilemma confronting the profession centered on whether recruits were genuinely interested in and loved nursing or were seeking it as a viable mode of employment. Students were paid a beginning salary of $1,396 a month (staff nurses start at $2,100), accommodation, or a stipend in lieu of same; meals, uniforms, shoes and caps were fringe benefits. This conflict of "paid studentship" was a constant theme of professional concern cited by practically all those interviewed. Some of their reactions were expressed in these ways:

> ... Getting a salary is reflected in the kind of care. They do not have the dedication; it is just a job ... (Interview, January 10, 1986).
>
> ... Students look for employment--they may get to love nursing afterwards--they do not specifically want to nurse ... (Interview, January 9, 1986).
>
> ... Many go in to get the salary and don't mind if they fail. Students are in there for six years ... (Interview, January 31, 1986).
>
> ... Many entered in the past because they loved nursing but in later years it may be for the money more than the love. Candidates who come in do so for more security--maybe if it were more of a stipend one would get those who really liked the profession ... (Interview, February 3, 1986).
>
> Many are talking about complete student status, I don't know if that will ever come. We still have to provide a service in the country. Young people think in terms of a salary and having a salary helps to support a family (Interview, January 27, 1986).

> The salary and the unemployment situation, these affect the recruitment adversely; we do not always get the type of committed and dedicated nurse we got 30 years or so ago (pre-independence) (Interview, January 13, 1986).

> It affects nursing and the calibre of students we get. It is seen as a job and security without the necessary commitment to learning. We would prefer to see them having student status and just given a stipend or something like that. Then we would be reasonably sure that probably the right type would be attracted (Interview, January 17, 1986).

There were those, however, although in the minority, who did not object to salaried students. They argued that students could be paid during training but not considered part of the workforce of the hospital. Their concern centered around the welfare of students many of whom had families to support (Interviews, January 9, 19, 27, 1986). This concern about the welfare of individuals is reflected in the economic and social policies of the nation, where the government as an employer sees itself as having a responsibility to provide a means of livelihood for as many persons as possible (Working Party, 1964:2). An interviewee captured it well, when she remarked "... the politicians said this was an area of employment [because] our people would not be able to maintain themselves ..." (Interview, January 10, 1986).

Not the salary, but a constellation of factors such as the environment in which students practice, the changing values of the society, and the family situation were seen as the critical issues in the training of students (Interview, March 19, 1986). Clearly, environmental factors, in both its wider and narrower sense, played an important role in student learning. As mentioned earlier, constant dissatisfaction with the hospital facilities and quality of care were the subject of a series of enquiries from the colonial era to the post-colonial period. The concerns of those reports about shortage of staff, inadequate supervision, shortage of equipment, and staff morale contributed to a less than desirable climate for student learning. In the broader context of the society at large, the influx of the petroleum dollars in the 1970s created a major change in the lifestyle of the majority of people. A large middle class was created, whose lifestyle and values reflected those of the metropolitan North American countries. Material goods were prized and community spirit diminished. This recent affluence was exhibited in a less caring attitude about the welfare of members of the society. It was a source of repeated concern expressed by many interviewees, as well as its impact on the behavior of nursing students. An interviewee stated:

> ... The society is less caring because we are self-supporting as individuals, but it might change with the economic downturn--that people will start sympathizing with each other and caring ... Money made the difference--the economy and the political system--both of them ... (Interview, January 6, 1986).

Other comments were:

> ... [There is a] lack of caring--the health care system is such that there are so many loopholes that need to be righted ... I believe there are factors in the society that affect the caring process and they are in the environment ... (Interview, January 24, 1986).

> ... While the oil boom helped us economically, the opposite occurred in brotherhood and fellowship ... We need ... to be more concerned in the practical aspects ... nurses are more concerned with monetary gains ... (Interview, January 27, 1986).

> ... Today the caring element is reduced to some extent. Lots come seeking a job because of the salary ... (Interview, February 7, 1986).

> There is ... less value on non-material--those personal things such as caring of a human being as opposed to the dollar. It is a societal thing but it is also reflected in nursing--people are less caring, as long as it doesn't affect them, they do not react--so that kind of thing is also in nursing (Interview, January 17, 1986).

Additionally, in the aftermath of the Black Power movement, especially among those who were born in the age of independence, many values were seen as the relics of a colonial era and were de-emphasized. Order, discipline, and respect for authority were de-valued. Punctuality and conforming to norms were seen as colonial and old-fashioned which led to a high level of absenteeism within the work situation and students followed the same pattern (Interview, January 17, 1986). An interviewee responded:

> ... our attitude to authority is confused with serfdom which is a drawback of political and economic advancement, people misinterpret and confuse order in organization with some form of slavery ... [There is] great difficulty in nursing [due to] absenteeism. Persons being trained cannot carry out their responsibilities properly because there is no supervision. Married nurses with children ill lead to absenteeism ... (Interview, January 31, 1986).

This latter observation, similar to others, alluded to the impact of the changing family structure on the workplace for staff and students. There was a breakdown in the traditional extended family. In the past, this extended family, which consisted of family, neighbors, and friends, would care for the children in the absence of a parent. With the majority of people working, including both parents, and the decline in domestic help, there was less caring and a change in family structure. Families became less closely knit than they were one or two decades ago. With the advent of new housing areas families moved away from their original sites. This led to a nuclear family structure and less time interacting with the extended family members (Interview, January 16, 1986). The older folk were placed in homes, and children in nurseries and day-care centers. Moreover, many children aged 11 plus to 14 plus were unsupervised due to the double shift system which existed in Junior Secondary schools. Thus children were left alone while parents worked which contributed to many social problems (Interviews, January 17 and 22, 1986).

Whatever the viewpoints, the initial professional concern, with regard to nursing students as public service employees rather than students per se, remained unresolved.

Staff Development

During the time when plans for the new nursing curriculum were in progress, the Nursing Division, in 1978, instituted a pilot project--a Staff Development Program. The need for in-service programs was evident to the nursing staff for a long time. A number of committees over the years had recommended same. The Beaubrun Committee (1975) was the most recent one to recommend that in-service programs be established at the three teaching hospitals. Valerie Foster, the then Director of Nursing Education, initiated the activity (Interview, January 24, 1986). The purpose of the program was to ensure that every nurse in an administrative position was given an opportunity to be exposed to the development of managerial skills, and to update those in the clinical field to current trends in nursing (Foster, n.d.). The program operated from three sites--Port-of-Spain, San Fernando, and St. Ann's--with a staff complement of three. A principal and two nursing instructors planned and organized programs to update staff.

The staff conducting the program were very well prepared. In a nursing population of over 5,000, where seven people had post-graduate preparation at the degree level, the staff development area had two such persons. The principal and one of the instructors, both locally trained, had Master's degrees from universities in the United States. They were working towards their doctorate with the principal in the process of completing her thesis. The instructor was in the data gathering stage and hoped to get a scholarship to complete course and thesis requirements.

After eight years of operation, the Program was still not officially recognized in terms of established budgeted positions by the Ministry of Finance. Something should be said here about the budgeting process. Nursing had no budget--neither the School nor the Division. This entailed lobbying on the part of the senior nursing personnel to ensure that recommendations got funded. Requests for increased staff were channeled through the Office of the CMO, Ministry of Health via the Permanent Secretary prior to final decision-making by the Ministry of Finance. The final outcome was a de-centralization of global budgets to the various centers.

Yet, the significance of the staff development program for the advancement of nursing education was clearly evident. The potential benefits of this activity for patient care and student learning cannot be gainsaid. In particular, students would have better prepared staff supervising them in the clinical setting.

Long-Range Planning

The Nursing Division recognized that the last group of nurses recruited from abroad in the 1970s were 30 years or older and that there would be a critical shortage before the turn of the century (Foster, n.d.). Consequently, in 1980, the Division requested the conduct of a Second Manpower Survey with PAHO/WHO consultants. The purpose was to develop a rational plan for the formation and utilization of nursing manpower in order to deliver the health services which were projected and needed for the decade 1981-1990. The findings revealed that nursing manpower had more than doubled during the years 1965-80, since the last Survey, which represented the best condition ever attained by any nation in the Caribbean area. Yet, the Basic Nursing Schools had not met their output targets of 180 new graduates per annum; less than 100 graduated each year, and it was envisioned that the number might further decrease due to the inability to attract suitable candidates to enter nursing. The harshest criticism was directed to basic nursing education. The Q and Q Survey Report (1980) stated:

> ... In each of the target areas, the poorest achiever was the Basic Nursing Education Programs. Either they had not been reviewing the targets or the School Administration had been too weak to seek excellence ... (p. 46).

Some examples cited were the high attrition rate, the inadequate numbers of clinical instructors for adequate clinical supervision, and a lack of clinical specialization among instructors. Strong advice was forthcoming:

> ... that unless drastic measures are adopted, the quality and quantity of nursing manpower will suffer and a setback in the delivery of nursing services will have to be anticipated. The direction of the Schools of Nursing must be placed in the hands of the capable, innovative, and far-sighted Professional Leaders. Those nurses who have moved ahead of their peers to acquire university education for themselves possess the progressive spirits, independent minds, and academic strength to lead the profession out of the current impasse. The problem had better be solved before another Commission is appointed to tell nursing what it should do ... (p. 46).

In particular, it was advised that "immediate steps be taken to ensure that the Directors of Nursing Schools assume the authority and responsibility for recruitment, selection, and enrolment of students" and that "priority be given to deploy more manpower to Nursing Education ..." (p. 64). In the area of Institutional Nursing, the greatest single problem identified was in the area of nursing service administration, with inadequate supervision at all levels due to lack of personnel. The study concluded with setting target norms to be achieved by 1990 for the entire nursing community, including projections for staffing in nursing service at the Mount Hope Medical Complex. Nursing education at the university level was not a proposed responsibility of the Nursing Division. Instead, the Advanced Nursing

Education Program was a component of the National Institute of Higher Education, Research, Science, and Technology (NIHERST). Its intended focus was on the preparation for nursing education, administration, and clinical specialization at the post-basic level.

In the mid-1980s, because of the economic recession, the preparation of nurse-educators slowed down (Interview, January 10, 1986). Disappointment was expressed by the Chief Nursing Officer when she lamented, "it is unfortunate that in the boom years none of the recommendations were implemented" (Interview, January 10, 1986). Furthermore, although there was an annual study leave program in the Civil Service, there was none granted to nursing since 1981. The Ministry of Finance and Planning was the final decision-maker as to priority of leave-granting. Additionally, no scholarships or leaves were granted to anyone in the Public Service over 45 years thus leading to early retirement (Interview, January 10, 1986). The first Principal Nursing Officer took early retirement in 1983, and the incumbent planned to do so in 1986. This does not imply that were the policy otherwise these individuals would have pursued further study, but it does preclude those who aspire to do so, and can be a counter-productive force in nursing.

Despite the government's emphasis on primary health care centers, with its expansion of these services in the less accessible areas of the country and the introduction of new programs, community health nursing was under-serviced. Funds continued to be put into institutional care instead of being directed to create the additional posts needed in the community health nursing service. In 1984, four years after the Q and Q Survey (1980), the community health field had only gained 1 percent of the nurse population instead of the 19 percent that was targeted (CNO Report, n.d.:9).

In order to advance nursing's contribution to the primary health care approach and the goal realization of health for all by the year 2000, the Chief Nursing Officer drew attention to deficiencies in the manpower complement. The urgency for the creation of 12 additional posts was called for in nursing education in order that the "quality and quantity of supervision given them [the students] ... be of a high calibre ..." (CNO Report, n.d.:3). In her Annual Report (n.d.) she proposed a recommendation, which if implemented, would have far-reaching consequences. This was a request

> To give the Nursing Division full authority and responsibility to manage the nursing services in a collaborative relationship with medical, administrative, and other health professionals and reporting directly to the Permanent Secretary (p. 1).

This concept was enunciated in the Q and Q Survey (1980:32) and was a resolution passed at the 11th Annual General Meeting of the Regional Nursing Body held in Grand Cayman Island in 1983. The resolution requested that Ministries of Health urge Member States to guarantee the following:

> ... Ensure that Nursing Division be administered by professional nurses, qualified by education and experience, who are given full authority and responsibility to manage the nursing service, reporting directly to the Permanent Secretary (cited in CNO Report, n.d.:4).

This resolution was subsequently submitted to the Ninth Conference of Health Ministers held in Dominica, July 26-27, 1984. At that meeting it was

> agreed that the nursing policy should be accepted by the Minister of Health as a tool for developing the nursing component of health care and be used also as guidelines by nurses in Member States to improve nursing as it relates to Primary Care (cited in CNO Report, n.d.:2).

Further, her Report made an appeal to the Ministry of Finance for understanding nursing's situation with regard to study leaves to prepare nurses for leadership positions. It pleaded:

> ... The Ministry of Finance does not seem to understand the plight in which [the] Ministry of Health has found itself because of the non-acceptance of major proposals for study leaves as far back as 1977-78 of key personnel for succession particularly in Administration, and to date we have not been able to meet our needs, and several officers have retired, and the remaining group at Central Command are due for compulsory retirement within the next four years (p. 2).

This was accompanied by requests for the creation of additional posts including the areas of nursing education and staff development.

In 1986, the Chief Nursing Officer still reported to the Chief Medical Officer, and both nursing education and staff development had no additional staff complement.

Summary

In the post-colonial period, the new national government's major thrust was to attempt to remedy the problems in the health services inherited from the colonial era. Its first action was to study the nature of the problems by appointing a local Commission of Enquiry into the hospital services, and to provide scholarships to develop indigenous leadership in nursing service and education.

In its efforts to be independent of its reliance on Great Britain, it turned to the United States and Canada for technical and financial aid. Consequently, the formulation and implementation of its Ten-Year National Health Plan was developed with considerable North American input. Sources such as the World Bank, Inter-American Development Bank, Pan-American Health Organization, and Canadian International Development Agency were major avenues for the provision of ideas, concepts, and values in health planning and policy-making. Nursing service and nursing education were thus influenced by North American nursing models in concepts and ideas. The impact of socio-economic and nursing events in the Caribbean region on nursing education locally coupled with initiatives taken by the indigenous nursing leadership to improve on nursing education resulted in a nursing program that was a mixture of British, North American, and indigenous features. Its nursing service, however, with its dearth of well-prepared leadership was slow to effect change and retained much of its colonial heritage in its administration and practices up to the 1980s, and nursing education was still an apprenticeship system.

CHAPTER VII

ANALYSIS OF DATA

In this chapter, the discussion of findings attempts to answer the research questions within the study's theoretical framework. The analysis focuses on two prominent themes rooted in the colonial past which recurred in the post-colonial era. These were: (1) the demand, supply, and preparation, for nursing leadership, and (2) effecting changes in the basic nursing programs to improve standards. Both issues had direct consequences for the development of nursing education in meeting the needs of the society.

The discussion includes an examination of the economic, political, and social forces described in Chapter IV and the health service events which contributed to those concerns. As well, international nursing perspectives that have relevance to the issues are considered.

Nursing leadership includes those personnel involved in the education of students and staff; and those in the administration of nursing education and service, institutional and community.

THEME I

THE DEMAND, SUPPLY, AND PREPARATION, FOR NURSING LEADERSHIP

A. The Colonial Era

From the time of Trinidad's colonization by the British in 1797 and Tobago in 1802, the colony's major economic activity was the sugar plantation. The West Indies were highly prized by the European nations as the sugar industry was profitable; and the use of slave labor, and later, after emancipation, East Indians as indentured labor in Trinidad and Guyana guaranteed a steady, cheap source of labor for the plantations. To maintain the viability of the plantations in the aftermath of emancipation, land policy was such that it was very difficult for estate workers of African and Indian descent to gain access to arable land. This ensured the workers' continued dependence on the estate owners through controlling the use of land for cultivation thus preventing the growth of independent peasant farming. It demonstrated an important feature of plantation economy which was the power the owners had over the workers on sugar estates. The class system of high status white land-owners and low status black and indentured East Indian laborers was thus perpetuated (Bacchus, 1980:17).

The economic and social relationships of the plantation system were replicated with regard to health care. In the early colonial period, the major concern of the British colonizers was the health and welfare of their expatriates in the colonies and the development of health policies was a by-product of this concern. From the days of slavery the need to train midwives evolved not from any altruistic concern for the welfare of slaves but for purely economic reasons as the plantation system was the major source of economic activity. Loss of slaves through illness and death meant loss of finances (Waterman, 1975). After emancipation, the same pattern continued, policies were enacted to safeguard the health of the expatriates, and while hospitals were established for the poor and a Board of Health and District Medical Officers were appointed to prevent the spread of cholera and yaws, yet health conditions were deplorable. Knight (1978:145) observed that up to 1896, Trinidad spent much money encouraging Indian immigration and on medical attention to the plantation laborers, both of which were necessary for the plantation system to survive.

As early as 1907, health conditions were the subject of a series of enquiries by the Colonial office. Mortality and morbidity rates, especially infant mortality, were high. After emancipation, many Negroes had migrated to urban areas and were the prime users of hospital facilities. Consequently, by 1913, there was an attempt made to design a three-year program for nurses based on the British pattern. Separateness between the two major ethnic groups was further encouraged by a health care system that provided a different policy for the East Indian population, since the estates provided their own medical officers for the indentured laborers. These conditions, added to the rural-urban dimensions of location and religious factors, promoted alienation of these two groups and accounted for the absence of East Indians in nursing (see pp. 52-53, 77, 84, 88).

The health care system then, as a sub-structure in the society, was compatible with the plantation system and through its organization and delivery helped to reinforce and reproduce the economic and social relationships which characterized the society. The plantation economy was not seriously challenged until the 1930s when there were uprisings in all of the West Indian colonies. In Trinidad, these uprisings were a direct result of the regrettable social and economic conditions which prevailed on the plantations and in the oilfields. Despite the high profits which were amassed, there was exploitation of workers through small salaries and unsanitary living and working conditions. The disturbances emerged in Trinidad among the working class in the oilfields and spread to the sugar estates. It brought into sharp focus the disparities that existed between the upper class white barons and the sugar lords and the working class Negroes and East Indians (Lewis, 1968:81-88).

The Moyne Commission investigating the insurrections understood that the fundamental problem of the region was economic but it was conservative in its recommendations for economic and political change. That period of revolt marked the demise of the plantation economy which required a docile and cheap labor force (Mandle, 1982:84). It also witnessed the rise of a labor movement among the oilfield workers and the emergence of nationalist politics. Public health conditions were, however, obvious to the Moyne Commission and were addressed. Reorganization of the medical services was advised in order to promote a focus on preventive measures; and attention was paid to the training of nurses which had been neglected for almost two decades.

Following the insurrection, during the war years, there was no attempt made by the expatriate Medical Advisor to enact a Medical and Health Policy or to unify the Medical Services as proposed by the Moyne Commission. Politically, power was still in the hands of the expatriates in the local legislature and in the metropole. Moreover, the Crown Colony system under which the country existed was "geared to getting things not done rather than done" (Lewis, 1968:205) which accounted partially for the procrastination. More importantly, implementing a policy that would enable West Indians, instead of expatriates, to assume leadership positions in the Medical and Nursing Services would not benefit the expatriates. It was clear that their position would be jeopardized by promotion of local personnel. As Carnoy (1974) observed, the colonizer "would not be able to do as well economically ... and could lose much of his self-importance if he were one of many ..." (p. 6).

The social and political forces in society which were pressing for unifying action evidenced in the efforts of organized labor had its effect on nursing. Trade unions showed them the importance of uniting to achieve improvement in conditions and laid the foundation for nursing cooperation. Thus, in the 1930s, nurses and midwives had joined together to form an association with the aim of raising standards of nursing and nursing education.

The drive for political autonomy and to assume greater control over their economic and social conditions in the society could not be stayed. The post-war period in which universal suffrage was granted could be described as one in which the desire to be independent of their colonial masters was the overriding thrust in the society. Regionally, it took the form of attempts to unite the islands politically but the failure of the Federation led to the development of national independence and regional economic cooperation. Other forms of cooperative endeavors evolved and nursing, as well, joined together to form the Caribbean Nurses Organization and a Regional Nursing Body. These organizations had a significant impact on nursing education in Trinidad and Tobago during the post-colonial era.

Similarly, in nursing locally, this post-war era witnessed the unification of nurses in the north and south associations which enabled them to become a greater force for attempting to bring about changes in nursing education. Intensive lobbying, to the various Commissions, by the Nurses Association ensued to agitate for registration and to assume local leadership of nursing education and practice. The hesitancy and delay by the expatriate senior medical and nursing personnel toward any assumption by the locals to leadership positions perpetuated feelings of inferiority.

Many of the solutions to the defects identified in nursing service and nursing education were not in the control of the "local" nurses, since authority was centralized in the hierarchy of the nursing services. The deficiencies in nursing reflected the quality of the leadership of expatriates in the health services--medical and nursing--who had the responsibility for five decades. This is not to say that local nurses were without deficiencies, but the concern here is with the prevailing pattern in the health services and nursing service and education, in particular, under colonalism. It must have been recognized by the Colonial Office that the calibre of nursing persons sent to the Colonies was questionable, as the Ruschcliffe Committee was appointed in 1943 to investigate the training of both the expatriates and the indigenous nurses. Memmi (1967) alluded to this phenomenon about the quality of expatriates--that it was the mediocre who tended to leave the home country for the colonies.

The criticisms by various Commissions combined with the prevailing societal movement toward freedom from the colonizer provided the impetus for local nurses to correct their educational deficiencies. Altbach and Kelly (1984:3) pointed out that an essential feature of colonial education was that schooling did not prepare the colonized for leadership in their own society. With the majority of local nurses prepared at the Primary School Level, and a lack of science in the education of girls at that time, it meant upgrading of nurses was essential to ensure entry into Tutor programs in Britain. Against these odds as well as unsatisfactory working conditions, the Nurses' Association worked assiduously to remedy defects, where possible. They organized courses with the aid of university personnel to upgrade nurses for entry to Sister Tutor programs, and were in the vanguard of the societal movement towards independence as registration for nurses was achieved in 1950, six years before the nation achieved self-government, and 12 years before it gained independence. This was no small feat for nursing and a major accomplishment of local nursing leadership.

While in the late 1940s there was some effort by the Colonial government to prepare local nurses for leadership roles by the provision of scholarships, it was "much too little and much too late." With the advent of self-government and a new national government, nurses eventually received scholarships, on a larger scale, for post-graduate education to provide for indigenous leadership in nursing education and service.

Leadership in the society, specifically in terms of public administration, was recognized early as a national problem of some magnitude. In order to achieve the rapid social, economic, and political progress desired by the people, the government saw itself as increasingly participating in the social, economic, and political affairs of the nation. It was to the Civil Service that the nation entrusted the administration of its day-to-day activities but it experienced difficulty in carrying out its responsibilities efficiently. The reasons for this problem could be traced to the colonial relationship. The Civil Service in the colonial era was essentially an agency of imperial power. The top administrator in all branches of the Service was British. Its whole structure, organization, and operation reflected the colonial relationship of the plantation system with expatriate administrators being the decision-makers and "local" rank-and-file clerks carrying out the routine tasks. Little knowledge or problem-solving skills were required of the locals. While, after Independence, many of the top Civil Service posts were filled by local intellectuals, yet the vast majority of persons in middle management positions of responsibility lacked the expertise and necessary problem-solving skills required for the job. As Lewis (1968:87) indicated the particular character of the colonial service was that its bias was political, rather than social or cultural, so that it was strong on the administrative side, in terms of its personnel for the colonies, and weak on the scientific and technological side. The absence of administrative expertise was thus apparent on the departure of the expatriates.

This critical problem of administrative leadership obtained as well in the health care system, and nursing, in particular. While scholarships enabled the preparation of local nurses for administrative positions in service and education, yet the demands far exceeded the output of prepared personnel. Health facilities expansion in the colonial era had created administrative and organizational problems in the delivery of health care with shortages of human and material resources. Further, there was no consideration during that time to groom local personnel to assume leadership positions or to place them in such positions to afford them the opportunity to learn on the job. Consequently, the nursing services inherited with the departure of the expatriates were not only in an undesirable condition, but lacked adequately prepared staff in both education and service for administering that rapidly growing service.

B. The Post-Colonial Era

Subsequent to attaining independence in 1962, the government, in its desire to be self-reliant and free from its colonial dependency, eventually shifted its focus to North America for loans from the IADB and World Bank, and technical assistance from PAHO and CIDA. This, in effect, meant dependency on Canada and the United States instead of Britain for ideas, concepts, skills, and expertise; and loans meant conforming to the development projects which Bank policies supported.

While the government was particularly conscious of any controls by foreign powers, it recognized that foreign investments, loans, and aid were necessary if it were going to achieve its development goals. There was, consequently, over a period of time, a general pervasiveness of North American influence in all aspects of the country's development process. In particular, the National Health Plan had the active involvement of PAHO/WHO, resulting in the subsequent decline of the British input and the gradual but steadily increasing Canadian and United States influences.

Regional and local studies in nursing (Q and Q Survey, 1968; Q and Q Survey, 1980; Survey of Schools of Nursing, 1966; Re-Survey of Schools of Nursing, 1971) conducted by PAHO/WHO in collaboration with regional and local personnel were instrumental in promoting changes to improve the quality of the nursing programs. The regional seminars, associated with the Surveys, which brought together administrators and teaching staff of the territories, and PAHO advisors, provided opportunity for sharing of ideas about curriculum development and nursing needs and resources. This collaborative effort was a motivating factor for the two manpower studies conducted locally. They facilitated long-range planning by establishing targets to improve on the quality of care and nursing education. Continued discourse through the Regional Body encouraged the development of

Regional Nurse Registration Examinations with the assistance of the Canadian Nurses Testing Services funded by CIDA. Economic considerations were a possible prohibitive factor in the delay of the implementation plans. Implementing such a project regionally entailed financial commitment on the part of each territorial government to subsidize costs; if this were not forthcoming from all territories the project may well lay fallow. Such a project required, as well, strong indigenous leadership to lobby internally, the Ministry of Health, and externally, the powerful Ministry of Finance which held the purse strings. Since the current leadership did not see themselves as influential in getting desired changes, it is doubtful whether they could successfully accomplish that goal or even consider it a priority, as it was never raised as an issue in any of the interviews. Another significant factor, with legal and political implications, was the role of the Nursing Council with regard to registration examinations. Regional examinations would diminish its power in that regard and would require legislation to effect those changes. Moreover, the control for conducting and setting examinations would be removed from local jurisdiction to regional with less local autonomy for both the Council and the Ministry of Health, and, consequently, less political interference by the Ministry of Health in Registration Examinations.

It would be an asset for nursing in the region if such examinations could materialize as it would ensure a minimum acceptable standard of nursing education regionally and could not help but benefit patient care in the Caribbean. The spirit of Caricom was to achieve Caribbean integration and while its initial intent was primarily economic, several cooperative bodies have evolved relative to all spheres in the societies. In education, Williams (1981:385) observed that the Caribbean Examinations Council (CXC) took a long time to come into being; it is hoped that the Regional Nurse Registration Examinations under the CXC's jurisdiction would fare better and realize its goal for the improvement of nurse education in the Caribbean.

The issue of regional registration highlighted two other significant issues. The first was related to the lack of clarity between the roles of the Nursing Council and the Ministry of Health with regard to final decision-making in nursing education. While it was clear that the Nursing Council had the legal responsibility for the examinations, it was over-shadowed by the government's political role exercised through its Ministry of Health. This was most evident in the selection of representatives to the Workshop on Regional Registration Examinations. Because of the quasi-governmental nature of the Regional Nursing Body, the Ministry of Health saw its role as making the choices, rather than the Council which had the legal responsibility, thus creating feelings of ill-will.

Secondly, this issue demonstrated the power struggle that occurs in small countries where opportunities for leadership are few and limited so that individuals in each group compete to achieve status and recognition. Along similar lines, Ryan (1972:350) contended that the smallness of the society tended to intensify jealousies and rivalries. This usurping of authority by the Ministry of Health, rather than having the decision made at the appropriate level or with the appropriate body, was yet a further indication of the centralization of decision-making which confounded the system. It showed how slow and difficult it was to change entrenched ideas and beliefs from the colonial era, because despite the structural changes for decentralization of authority and decision-making in the Ministry of Health and the rhetoric of same, centralization occurred even when the opportunity to do differently was apparent. Ryan (1972:361) pointed out this type of bureaucratic administrative behavior was very much influenced by the history and traditions of the society and often persisted for centuries despite political changes.

Reorganization of the Health Services - The Role of Nursing in Policy-Making

It was intended that reorganization of the Health Services would provide for decentralization of authority and, therefore, alleviate the technical and administrative problems encountered, but as indicated, while the structures were in place the process of decentralized decision-making was slow to change.

In the new structure, key policy decision-makers were the Minister of Health and the Permanent Secretary, as the senior civil servant, with advice from the Chief Medical Officer. Ultimately, however, it was the Prime Minister and his Cabinet who were the final policy-makers for health care. Generally, policies were developed from the community level. These were often the result of recommendations from the grass-roots with further discussion at various levels before going to the Permanent Secretary and the Minister of Health (Interview, March 4, 1986).

The creation of a Nursing Division with senior administrative personnel and a Chief Nursing Officer was an important element in the revised structure. It was envisioned that the nursing administration would be involved in policy formulation and program planning. Nursing leadership, however, was slow to take action in the decision-making relative to those areas. From the outset in the 1960s it was involved instead in activities that were more appropriate at the operational level. This phenomenon was understandable as the social and psychological nature of the colonial relationship ensured "doers" not "decision-makers" or "thinkers" where reliance for final decision-making was centralized in the hands of the expatriates. Barrow (1969), in her keynote address to the Caribbean Nurses Organization, attested to the existence of these features of the colonial heritage by observing that:

> ... The nurse ... was not given the preparation to rise to the decision-making group within her profession. She was not given the preparation for thinking, but simply for doing ... The age of autocracy was also with us. Senior personnel within institutions had somewhat the divine right of 'Queens' and, let us be honest, exercised this right ... (p. 169).

This was coupled further with a practice discipline that historically emphasized "doing" not "thinking."

There was nursing input, however, within recent times, in policy-making and program planning through participation on the Policy Planning Committee as well as nurses' participation at various levels in the health care system in the planning process. Yet, the Nursing Division did not view their role as influential in the policy-making and planning process, and sought to achieve this by arguing for direct reportability by the Chief Nursing Officer to the Permanent Secretary similar to that of the Chief Medical Officer. This concept was promoted in recommendations of both regional and local studies conducted by the metropolitan advisors. Local leadership felt frustrated in their efforts to affect decisions regarding the future direction of nursing; reporting directly to the Permanent Secretary was seen as a means to achieve this. But nurses did not appreciate the fact that they were having a say in the policy-making process and down-played their role (Interview, February 28, 1986). Moreover, they did not always grasp opportunities to put forward policy papers as it affected nursing and patient care (Interview, March 4, 1986). This was another indication of the colonial relationship where reliance for final decision-making was formerly in the hands of expatriates and even though the condition no longer existed, the leadership did not grasp or recognize opportunities for initiating policies, or were not cognizant that they were making policies.

This is not to imply that their claim to be able to affect decisions regarding the future of nursing was unjustified, as there were repeated occasions* when their input went unheeded, but whether direct reportability to the Permanent Secretary would ensure implementation of plans or greater policy input is a moot point.

The long-term plans outlined in the Q and Q Survey (1980) supported by the Nursing Division are illustrative. The plans for nursing education emphasized the need for an increase in the complement of instructors, and for the assumption of authority and responsibility for nursing education by Directors of Schools of Nursing, along with the transfer of nursing education to the Ministry of Education or similar body. Neither of these ideas were novel as they and others, similar in intent, had been suggested over the years. Why then were they never implemented? It was obvious that recruiting or preparing additional instructors would increase financial costs. If while the economy was buoyant no action had transpired, it was unlikely to occur during the economic downturn in the mid-80s. But this still does not answer the fundamental question as to why there had been no relative increase in instructional staff, and no change in the structure and organization of nursing education given, as well, the Ministry's apparent concern for student attrition and failures in the program. The answer can be found in three interrelated factors.

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*Refer to pp. 115, 164, 165, 170, 185-90.

The first is the colonial heritage of a lack of long-term planning and preparation for leadership positions. Careful planning would have resulted in a broad base of prepared managers and educators. In the post-colonial era, the supply could not keep pace with the demand created by population growth and expanding health facilities. While some attempt was made to provide for qualified and well-prepared staff in the Nursing Division, the seniority principle was adhered to which, apart from the administrative problems it engendered, caused low morale and disaffection among younger, qualified and experienced staff. This seniority principle was another dimension of the authority and power phenomenon of colonialism. In the past, there was little or no opportunity for mobility as the expatriates held all the top posts. In a small country, where there are few senior administrative positions in nursing, there are more aspirants vying for this opportunity to achieve status including those who were denied such opportunity in the past. Barrow (1969) made such an observation when she asserted that:

> The concept of self which the nurse of the Caribbean had was inculcated in her by the status afforded her. For the first part of the century it was difficult for a nurse of the Caribbean to aspire to a very senior position in her own country. The preparation provided for her within training schools was not designed to so prepare her. Finally, when these positions were opened it was stated in government regulations that the aspirants had to be holders of a qualification obtained outside the area. This was one which would not be considered for top level positions in the country in which it was obtained ... (p. 169).

Seniority then facilitated status achievement, added to which the Public Service Association stressed seniority more than other attributes. It was more welfare-oriented than task-oriented (Ryan, 1972:353). Efforts to break the seniority cycle had on rare occasions occurred in the past and was anticipated in the future. Still, it seemed that old attitudes to seniority and status prevailed. With three senior administrative positions available in 1986, time will tell if more than lip service was given to changing the status quo and appointing the academically well-prepared junior staff. Or whether as Barrow (1969) noted "the old attitudes to status have percolated so far down that although new people have filled the positions many of the old attitudes remain" (p. 170).

The second factor is the image and status of nursing. Nurses saw themselves as powerless, a universal phenomenon experienced in a profession that is primarily women, but compounded because of the colonial past. Much has been written about the image of nursing and its status. The history of nursing internationally has been, from primitive times, bound to the female of the species. The development of nursing in the metropolitan countries consequently reflected the women's movement and the struggle for their emancipation. As Donahue (1985) pointed out "the oppression of nurses was built into the law and the educational system through the legislation of paternalism and the institutionalization of apprenticeship" (p. 355). Traditionally, women do not possess power and although strides have been made within recent years, nursing is seen as embodying the traditionally female, expressive role. Socialization of men and women into particular roles has been accepted as a major reason. Cultural indoctrination is particularly evident in Trinidad and Tobago where women are generally acquiescent, and where males see themselves as the dominant figures. Smith (1978) in his study of Educational Policy in Trinidad and Tobago observed such a phenomenon when he found that women rejected the suggestion that more women should be appointed to supervisory positions. He asserted: —

> It may be that women perceive themselves as being unequal in stature with men and have somewhat internalized this as a philosophy. They have been thought of principally as homemakers, and hence the purpose of their existence was to complement that of men. While this sounds chauvinistic, one has to understand that the frame of reference for this society is based on a combination of European, African, Chinese, and East Indian traditions all of which subscribe to male-supremacist thinking (p. 136).

In the health care system where a great deal of politics and power are used to control or create change, women are disadvantaged partly because their socialization has not taught them the corporate game (Stevens, 1983:5). The image of nurses in society has reflected the image of women in general. Kalisch and Kalisch (1983), acclaimed experts on the image of nursing, identified a number of characteristics that demonstrated the universality of this global issue. They maintained that negative images affected the quality and the number of persons who chose nursing as an occupation and further, that these images affected the decisions of policy-makers relative to the allocation of scarce resources for the profession, namely, money. Additionally, the negative portrayals affected the nurses' self-image and undermined their self-confidence and value. Clearly, these observations held true for nurses in Trinidad. The profession did not enjoy high status in the society and its dearth of well-prepared leaders heightened that perception. Further, the salaries of senior nursing leadership were far below those of their male counterparts in other public service areas. Additionally, another significant aspect which contributed to the nurses' low self-esteem can be traced to their colonial heritage. This was pointed out by Barrow (1969) who maintained that:

> With limited possibility of promotion in the senior positions of responsibility in her profession if she were 'locally' trained, with legislation which actually decreed a first level qualification of one country only outside the area as criteria for appointment to such a position, the West Indian nurse of that era tended to think of herself, if she thought about it at all, as very low on the totem pole of occupations ... her role appeared to be one in which, although she was giving valuable service of a community nature, there was little value put upon her as a person or as an individual ... This did not give much assistance in changing the self-image of the individual ... (p. 169).

In the 1980s, despite the fact that the nurse was not hindered for promotion because of her local training, much of what she stated was still evident. Landauer (1970) also drew attention to the impact of colonialism on nursing. She argued that it discouraged local initiative and worked in two ways reinforcing each other. It was expressed in these terms:

> She was handicapped, first, by the postulate of the 'natural' inferiority of women which is so generally accepted of the ancient culture and religions of the Eurasian continent. Secondly, nurses until recent times, and not only in the colonies, were mostly apprenticeship-trained, and during this period of initiation, were sources of cheap labor, rather than students. Thus, the native nurse from the day she entered on her career was surrounded by her metropolitan superiors, whether nurse, medical professional or administrative officer all better prepared than she was and all living on a standard much superior to hers in a world to which she was a stranger ... (pp. 177-178).

Nurses felt thwarted at their lack of success in effecting the changes they saw as desirable for the profession. The need for more instructors, for increased funding to provide scholarships to prepare staff for administrative and teaching roles, for greater control over nursing education and its transfer to higher education were major concerns. In this regard, nurses in Trinidad and Tobago obviously experienced similar struggles in their image and status as their metropolitan counterparts.

The third factor was the nature of policy-making to which the national government subscribed. The resistance of the government to transfer nursing education to the National Institute for Higher Education, Research, Science, and Technology (NIHERST), or to make organizational changes to permit greater control by schools of nursing for student learning can be found in the pattern of economic development that the government pursued from its inception. It embraced a "middle-of-the-road" compromise where there was continued reliance on outside investment, but also a steady and increasing local control over the economy. It favored incrementalism not radical change. The "Black Power" movement in 1970 was, in large measure, a revolt against the government's development strategy which was perceived as maintaining the status quo and not producing radical reforms. Even the educational system, which was to be the key to decolonization and to creating a national identity, was slow in effecting change in its subject content relative to the local culture and was the object of much criticism. This entrenchment of ideas and practices has been acknowledged by many writers on colonialism. Clignet (1978:84) argued that because the colonized is only exposed to the elements of the colonizer's culture it facilitated a perpetuation of the colonial era. In a similar vein, Bacchus (1980:257) in his study of Guyanese education, observed that the school curriculum continued to be irrelevant to the needs of the country despite efforts to reform the curriculum by the national government. Further, Mandle (1982:141) pointed out that, given the political stability demonstrated in the nation, prior to and following the death of Eric Williams in 1981, "the United States has looked favorably upon Trinidad as a bastion of conservatism in the region." It could be expected that changes in the health care system would follow a similar pattern. Therefore, it was highly unlikely that the government would either agree to or implement changes in nursing that would require a total reconstruction of current practices. Moreover, this tendency to incrementalism would be further reinforced by the nature of nursing in that nursing practice deals with the reduction of risks as opposed to risk-taking which would occur as a result of any radical changes in nursing education. These considerations help us to understand why there has been basically no movement to initiate major reform in nursing education. It would be a political decision with far-reaching economic and administrative ramifications.

In the United States and Canada, such a transfer of authority and the need for better educational preparation of nursing students took several decades to achieve. As discussed earlier, from the 1930s to the 1960s, numerous studies in both metropoles had advocated the transfer of nursing education to institutions of higher learning. Its accomplishment was uneven and fragmented with hospital schools still existing up to the 1980s though administered under the aegis of education. Nursing education, nationally and internationally, showed striking similarities with regard to policy implementation. Major changes in the metropolitan countries were incompatible with the history of policy-making in those societies which generally tended to be incremental. Hofferbert (1974:263) contended that the reason for this was both socio-economic and political, as these factors placed constraints on policy-makers limiting their capacity for innovativeness thus "incrementalism" occurred. Policy-making in nursing mirrored that of its particular society.

Policy-making in the health services during the colonial period, similar to the British pattern, was slow both in its formulation and in its implementation. This would also be a contributing factor in the concerns expressed by local medical and nursing personnel about the lack of action in implementing required changes.

In the post-colonial era, the three Five-Year Development Plans and the National Health Plan contained many initiatives for the health field. A concerted effort was made to effect changes on all fronts. Over a period of two decades, there was reorganization of the health services, an extensive building program including the construction of additional health care centres, training of professional and administrative personnel, creation of a Nursing Division, and an assessment of nursing manpower requirements. The years immediately following the First National Health Plan was characterized by crisis management. With the economic boom, there was, ironically, greater centralization of planning through the Ministry of Finance. As Ryan (1972:356-362) contended, one of the key blocks to efficiency was the Ministry of Finance. Because of the lack of confidence in the judgment and reliability of Civil Servants, the Ministry of Finance maintained an extremely tight rein on operational expenditures of the entire public sector, and while this policy was obviously designed to ensure proper financial accountability and to reduce public-sector costs, beyond a point, it was dysfunctional.

Political factors may have had, as well, something to do with this lack of planning. One interviewee remarked "The political climate dictates to what extent that expertise [the health planner] will be used or not. It depends a lot on how the senior administrators view planning" (February 28, 1986). By the early 1980s, plans were in progress for a Second National Health Plan under the leadership of a vibrant, well-prepared local health care planner (United States prepared) which added credence to the preceding view. Further, this plan was a major attempt by government to be self-reliant in its planning and development with entirely local input at a variety of levels including nursing.

The pattern, then, of government policy-making in the health arena was to progressively make changes that were moderate in approach without any radical reforms, an approach that was congruent with its overall economic policy-making where it endeavored to maintain a balance between national ownership of industries and foreign capital. The inherited colonial pattern of policy-making persisted, one which was slow, moderate, and incremental. Similarly, nursing policies were implemented only after successive reports and recommendations advocated a particular path. Because nursing played a significant role in the delivery of health care, student education and consequently patient care were hindered by that incrementalist approach. There had been no action by the government since 1978 to provide adequate funds for the preparation of nurse managers or instructors. Annual study leaves since 1978 were no longer granted to nursing creating a further dearth in those already scarce resources. The fact that they were primarily a female group was a major contributory factor for all the reasons outlined earlier relative to the image, status, and power of nurses. This brings us back to the original claim of the Nursing Division, supported by the Q and Q Survey (1980) and the Regional Body, that the CNO report directly to the Permanent Secretary so as to have greater policy input. While that line relationship could undoubtedly influence the particular incumbent in the role of the senior administrative civil servant, it is far less certain that it would influence policy implementation which was a central nursing problem. Yet, this is not to deny the importance of nursing, as a separate profession from medicine, reporting directly to the Permanent Secretary. Its critical role, in the vast majority of health programs delivered in the nation, warrants such a structural change in line relationship. However, such a change is predicated on the condition that academically well-qualified, assertive, and experienced nurses occupy the chief nursing roles in the Ministry as vacancies occur. As an interviewee observed:

> ... The technical Officers [senior Ministry nurses] must be able to see themselves on a par with others. Nursing must put the appropriate level of persons at the head office. You must prepare your nurses to participate in this decision-making level. The time has come that we have to put in head office the nurses who are capable by qualifications, training, even just by physical presence to make the kinds of impact on the system that we need ... (Interview, February 28, 1986).

Sources of Ideas and Values in the Preparation for Nursing Leadership

Regional cooperation facilitated efforts in nursing. Subsequent to the departure of the British expatriates, the formation of the Caribbean Nurses' Organization and the Regional Nursing Body had significant implications for national nursing. The former provided opportunity for sharing ideas regionally and internationally, and the latter was instrumental in raising the standards of nursing education through the encouragement of local studies and the conduct of regional studies. The two regional surveys of nursing education conducted by PAHO/WHO in collaboration with the senior nursing personnel in the territories in 1964 and 1968 provided the first major source of Canadian influence. Further, regional collaboration provided the stimulus for the local nursing leadership to initiate curriculum changes and to conduct manpower studies into the quality and quantity of resources to assist in long-range planning. Both of these activities involved North American input--Canadian and American--through PAHO. As well, indigenous university preparation at UWI, Jamaica in 1966, in administration and education was a major regional accomplishment. This was congruent with the national government's philosophy that education at all levels was the key to decolonization, and in particular, a "local" curriculum. The program provided the first opportunity for nationals to undertake Caribbean preparation instead of British. It, however, required the technical and financial assistance of PAHO in its development; and consequently, there was the inevitability of North American ideas and concepts. The program, nonetheless, was developed with a cultural focus and operated within a Caribbean context.

Additionally, in the society there was greater exposure to North American values since the war years, with the location of naval bases in the island and through the media. Further, with the influence of petro-dollars, travel, and migration to the metropolitan countries had increased. Consequently, nurses pursued advanced studies in the United States primarily, and Canada, instead of Britain. They were inevitably influenced by the ideas, values, and concepts of those countries which they brought to bear in the areas of staff development and student education where they were placed.

To further meet the demand for prepared managerial and instructional personnel, local interventions took the form of workshops and in-service programs. Yet, this latter programming area was understaffed to meet the burgeoning needs for administrative, educational, and clinical leadership required in the nation. Hope was centered on the university degree program, planned to commence in the future at the Medical Complex, to remedy the situation. While there was a small cadre of well-prepared staff able to assume administrative and teaching positions, yet their loss, from the nursing education and staff development programs would further deplete the already scarce resources. This would leave the basic problem of a lack of skilled nursing leaders as managers and instructors unresolved, and nursing education embedded further as an apprenticeship system.

THEME II

CHANGES IN THE NURSING PROGRAM TO IMPROVE STANDARDS

A. The Colonial Era

The first nursing program in 1913 was three years in length and modelled after the British pattern of Florence Nightingale, under the guidance of the expatriate Matron of the first hospital on the island. Doctors, the Matron, and her assistant gave lectures and the system was one of apprenticeship where students learnt on the wards as a part of the staff. A few years later, a local feature introduced was the requirement of a one-year midwifery course in order to practice as a nurse. While this was attributed to the fact that maternity patients were nursed next to patients in general wards, it was also a way in which local nurses were kept as cheap labor in the hospitals for as long a period of time as possible. Neglect of the program in the 1920s and 1930s led to a deterioration of standards. Thus, by the 1930s, with social and economic unrest due to the unhealthy conditions which prevailed, there was expansion of medical and nursing services. Consequently, greater skill was required of nurses and concern was expressed that applicants were below required standards. While attention was paid to selection of applicants, program revision did not occur until the subsequent decade. This was achieved largely through the efforts of the local Nurses and Midwives Association which was active in lobbying the various Commissions of Enquiries (Foster, 1937; Moyne, 1945; Rushcliffe, 1945) for desired changes in order to improve standards of education and care on the island.

Revisions were made in both the content and program length along with the appointment of two qualified tutors. Because of the prevalence of tuberculosis, the length of the training period was increased from three to four years to accommodate experience in tuberculosis (TB) nursing, with midwifery maintained in the fifth year as an added requirement. While it was obvious that extra time was needed to provide experience in the nursing of patients with TB, it is questionable whether an entire year was necessary to accommodate such experience. It provided, however, a further legitimate reason for the continuation and prolongation of a system of cheap labor.

Theory was increased with the introduction of a block study period and a preliminary training system of three months. Both of these features were then present in the British hospital schools of nursing. These program changes and the advent of two prepared Sister Tutors, local and expatriate, assisted in the achievement of registration and the formation of the Nursing Council. The transfer of responsibility for curriculum content, program length, and examinations from hospitals to the Council was in effect transfer from expatriate control to local control which served to boost the pride of indigenous nurses.

A major thrust of the new leadership was its focus on more effective recruitment practices though it was unclear as to the success of those efforts. Additionally, by 1952, the program was shortened from four years to three years, including the maintenance of the three-month Preliminary Training period. The shortening of the program could be viewed as an attempt to curb the use of students as cheap labor. A new element introduced permitted entry as a student nurse after assessment of the student's adaptability for one month on the wards; and Preliminary and Final examinations were instituted maintaining the British system of oral, practical, and theoretical components.

From its inception, the Nursing Council worked closely with the General Nursing Council of England and Wales (General Nursing Council) as its ultimate goal was to obtain reciprocity with Great Britain. It depended on the metropole for advice, expertise, and written documentation, and despite improvement of standards, the General Nursing Council took several years to grant reciprocity. The problems identified by the General Nursing Council of insufficient tutorial staff and overcrowded hospital wards had, however, existed prior to the formation of the Council, when the health services were under the control of the expatriates and, in fact, still was in 1953 when the recommendations were made. Moreover, it is questionable whether these factors were any different in Britain at that time. Because even in recent times, Bowman (1986) contended that:

> the present obvious dissatisfaction of nurse teachers with their status, authority, working conditions, and great responsibility ... and the long-standing imbalance in the ratio of teachers to students must inevitably ... have a ... crippling effect ... and ... aggravate declining standards of care (p. 276).

This is not intended to imply that reciprocity should be granted whatever the conditions, but it is intended to demonstrate the nature of the colonial relationship where the local nurses had no control over those conditions but were expected to rectify the situation. As Memmi (1967) observed the colonized had no power but the colonists came not only with power in the situation but had the might of the metropole behind them. Reciprocity was ultimately achieved in 1958. This was a prestigious accomplishment for the nurses as great value was placed on Britain's recognition of standards achieved locally and helped to alleviate feelings of inferiority. This was a common phenomenon in colonial relationships where the colonized had feelings of inferiority that correlated with the European's feeling of superiority (Fanon, 1967:93). Similarly, Memmi (1967:5) pointed out the conflict that occurred with the colonized, when he asserted that "the oppressed are not filled solely with resentment against their oppressors; they also admire them" and so emulate them and aspire to attain their attributes and positions.

In summary, during the colonial era, the first nursing program in 1913 was three years in length patterned after the British system of training. It was an apprenticeship system and students received lectures by doctors, the Matron, and her assistant. The model continued with deterioration in standards due to successive changes of Matrons of questionable quality during the 1920s and 1930s. Social and economic unrest on the island due to insanitary health and social conditions combined with the lobbying by the local organized nurses association led, in the 1940s, to substantial changes in program content and length to improve standards of education. By 1950, transfer of control of nursing education from expatriates to local leadership had occurred with the formation of the Nursing Council. The practice arena, however, remained in the hands of the expatriates.

Changes instituted during this period were based on the assessment of local nursing standards by the expatriates and were patterned on British standards and practices. Even with autonomy in terms of registration by local personnel, nursing relied on the British system as a model of excellence and a yardstick by which to measure their programs, and to achieve recognition and status through reciprocity.

B. The Post-Colonial Era

The Nursing Council continued to make changes to improve the quality of the program. The registration examinations maintained the British tradition of practical and theoretical components, but the oral part was eliminated. Recommendations emanating from the Basic

Education Workshop (1966) and the Q and Q Survey (1968) led to a number of curriculum changes. The British pattern of the three-month Preliminary Training School was discontinued and the program was shortened to three years. The inclusion of content in obstetrics, psychiatric nursing, and community health in 1968 with the subsequent discontinuation of the single trained mental nurse program in 1969, and the introduction in 1970 of a one-year post-basic psychiatric program for registered nurses were the direct result of Canadian and United States ideas and practices. The termination of the local practice of having staff nurses complete a one-year midwifery program as a prerequisite to promotion as a ward sister was another change implemented and recommended by the Q and Q Survey (1968). Both British and North American experiences were influential in effecting the introduction of the nursing assistant program to strengthen nursing manpower (see p. 166). Similar action had taken place in the metropolitan countries. In Canada and the United States, practical nurses had been in existence prior to World War II although they did not become licensed to practise in the United States until 1944 (Dolan, 1973:274). In Britain, they were introduced after World War II when shortage of staff was experienced (Blueprint, 1956).

National initiatives in the society at large had an impact on the quality of applicants and their ethnic representation. With the advent and expansion of free secondary schooling, in the 1960s, to remote areas of the island, most students had a variety of choices open to them. It also provided a larger pool of prospective candidates who were educated beyond the primary school level. Additionally, the oil boom in the 1970s had created a large middle class whose parents could afford to educate their children abroad, if desired. Yet, nursing remained a viable option for many, as it provided a satisfactory means of livelihood, especially among those who were unable to achieve five GCE "O" levels. Although the majority of the population were Negroes and East Indians, the former were the primary ethnic group in nursing up to the 1960s. Geographical location as well as religious and cultural factors contributed to this imbalance. The concentration of East Indians in the rural, agricultural areas meant there was less likelihood of their entering nursing, as the two general hospitals were located in the urban areas. Moreover, Hindu religious practices and values favored early marriages for girls rather than careers. However, with the accessibility of secondary schooling in rural areas and the gradual "creolization" of East Indians many sought entry into nursing resulting in a more balanced ethnic mix in the 1980s.

A further change, in the 1970s, was the use of a Selection Committee to facilitate better screening of candidates. While the use of this Committee may have helped in eliminating unsuitable candidates, counteracting it was the lengthy admission process which was a possible detractor to suitable candidates.

The age of mass media communications and the North American ascendancy, internationally and nationally, promoting the American way of life encouraged the migration of nurses in the late 1960s with decreasing numbers in the 1970s. Further, the feature of continuing staff shortage was related to unsatisfactory terms and conditions of work. The lure of profitable jobs abroad and the opportunity for post-graduate study have contributed as well to the brain-drain (Chan, 1975:26). This brain-drain to the metropolitan countries created a vicious circle. It increased strain on the already scarce resources, leading to a further lack of adequate supervision of student nurses and deterioration in standards of patient care. The brain-drain problem, however, viewed in its true perspective was many faceted. At the Caribbean Health Ministers' Conference in 1969, it was pointed out that people have always tended to move from less prosperous to more prosperous regions even within the same country, and that there was a constant brain-drain from rural to urban areas in most countries, which was induced as much by the changing pattern of agriculture as the wider opportunities which were available to ambitious and enterprising persons in the cities. It was argued that the desire to move to more prosperous or progressive areas was a natural tendency of professional and non-professional people alike, and it was seen as a tendency that was likely to remain as long as men and women aspired to better their condition (1969:25). It has been proposed by others that professional migration from developing countries appeared to be not a drain but an overflow in ~~that "the~~ less developed countries (LDCs) are not being stripped of manpower they badly need; more often than not they are being relieved of manpower they cannot use" (Baldwin, cited in Garcia-Zamor, 1977:81). While this did not apply in its totality to nursing, it did play a significant part, as many nurses trained abroad had no assurance on return home that their particular skills would be utilized. This condition obtained in the Civil Service where returning nurses were compelled to follow a step-ladder approach regardless of expertise. Further, immigration policies of the three dominant metropoles facilitated the flow of trained personnel into their territories (Garcia-Zamor, 1977:82). Moreover, registration reciprocity with Great Britain no doubt would have also contributed to the outward movement. To counteract this outflow and to alleviate manpower shortage in the late 1970s, there was recruitment of nationals trained abroad which provided another source of primarily British influence.

Student failures in the registration examinations from the late 1960s was an area of major concern throughout the ensuing decade as it further compounded the manpower problem. Repeated studies by the Ministry of Health in an attempt to isolate causes led to periodic adjustments in admission requirements, up to 1982, in an effort to maintain an optimum balance between increased enrolment and success in examinations. While it is too soon to determine with any degree of confidence the outcome of those efforts, nonetheless, from the available evidence, it appeared that enrolment increased. This was partially due as well to a down-turn in the economy, in the mid-80s, which meant that nursing was an attractive occupation for many. The many changes in content and examination format introduced by the Council in the late 1960s may also have contributed to the students' lack of success. The Council continued, however, in subsequent years to make revisions to improve on the examination format and procedures. Registration results between November 1979 to May 1982 indicated a marked improvement from previous years, ranging between 73 percent and 93 percent (Council statistics). Whether this can be attributed to improvement in registration examination questions, methods, and procedures, or to improved clinical supervision due to reduced numbers of students, or to higher educational standards is difficult to say with any degree of certainty. Possibly, a combination of all these factors had a bearing on the outcome. The effects of lowering the entrance requirements on future examination results, however, would not be apparent for some time yet.

The Nursing Division, as well, took actions that had significant positive effects on the nursing program. Its staff development program through its varied programming undoubtedly served to increase the managerial and clinical skills of the nursing staff, many of whom supervised students on the wards. Of greater significance was the development of a new curriculum which was an endeavor of major proportions. The Core Committee established in 1976 was able to capitalize on the curriculum guidelines of the Regional Nursing Body, and incorporated indigenous concerns and international trends in nursing and health care, with the assistance of the PAHO/WHO Area Advisor. The end result was a sophisticated integrated curriculum which reflected North American ideas in its conceptual framework and format while incorporating significant indigenous elements. Because the enunciated health policy of the Ministry of Health was in the area of preventive care, the nursing curriculum was designed to be family-centered and community-oriented, and focused on the promotional and preventive aspects of health care. It addressed the cultural aspects of the society thus bringing a distinctly national character to its otherwise metropolitan outlook. Further, the two-pronged approach to nursing education, with a core curriculum of 18 months, which allowed some students to become registered psychiatric nurses was a distinctive indigenous feature. While the validity of this approach, reinstituted in 1978, has been questioned by metropolitan advisors and seen as undesirable because psychiatric nursing is advocated as a post-basic program, yet the current nursing leadership are to be commended for their initiative and persistence, not only in instituting this unique approach to meet the needs of the society, but doing so despite metropolitan pressure to the contrary.

Core curriculum planning of various kinds has been recommended and implemented, from time to time, in metropolitan countries as an effective way to organize curriculum where similar content is required for learners in different or related disciplines (Hezekiah, 1975; Uprichard, 1973). It would seem that its validity would depend on whether or not it was meeting the needs of the Trinidadian society. It is inappropriate in developing countries to prolong periods of nursing education based on North American models, if other, more appropriate models based on cultural needs and differences can be developed. They are worthy of consideration and no less desirable.

Further, since these nurses are registered with the Council, quality of nursing standards are assured. This area of mental health nursing education was beyond the scope of this study, although it was briefly addressed within the context of the development of basic nursing education, and was a particularly outstanding indigenous element.

These indigenous features demonstrated the value that had been placed, particularly since the February "Black Power" revolution of the 1970s, on decolonization in all aspects of the society. It was consistent with Ryan's (1972:373) observation that decolonization [had] been taken a step further as a result of the "February

Revolution." On the other hand, the aftermath of that event had some undesirable consequences for society which were reflected in nursing education. The values of discipline, the work ethic, respect for authority, law and order, some of mankind's safest and oldest moorings, were cast aside as colonial. Additionally, there was an increasing North American presence in all aspects of the society and the greater affluence among a broader based middle class who were able to travel frequently to Canada and the United States. This led to a process of "Americanization" or "the diffusive influence of the American 'way of life'" (Lewis, 1968:33). The breakdown of the extended family, with the nuclear family and working parents as the norm, promoted a lifestyle that was self-centered and materialistic. These characteristics of the 1970s appeared in the nursing practice of staff and students in the guise of absenteeism, rudeness, indifference, and a lack of caring toward patients and peers.

Another significant change of a national nature was the notion of salaried students. While students in the colonial period received an allowance, nursing students in the post-colonial era were assured of a decent wage which was a reflection of the government's welfare-oriented policies in its process of decolonization. The government saw itself as the chief employer of the people to ensure their economic and social well-being, and the Civil Service was seen as a principal decolonizing agent. Consequently, students were considered Civil Servants and paid a salary.

In implementing the new curriculum some changes were achieved which were congruent with the theory. Students received experiences in a variety of community settings other than the traditional illness-focused hospitals, and the school retained the right to determine the particular setting for groups of students. The greatest stumbling block to implementation lay in the organized system of nursing education where there was a lack of autonomy in implementing the curriculum. The needs of the hospitals still determined the organization of the curriculum to facilitate staffing, so that the inherited British tradition of a block system was maintained. As well, the lack in the quality and quantity of instructors and the perpetuation of student supervision by ward staff inevitably led to a gap between the espoused theory of the new curriculum and day-to-day practice.

Equally important, was the fact that the hospital maintained, in the final analysis, control of the students' learning experiences instead of the school, with the result that service needs assumed priority despite a sound theoretical component. Further, the practice area maintained the colonial pattern of administration characterized by a hierarchical and authoritarian structure, added to which, there was a dearth of well-prepared management personnel at the unit level. Even the trappings of the colonial days still held sway symbolized in the style, pattern, and color of the student uniforms which were similar to those worn in the pre-independence era, and including the "standing to attention" at the presence of the Matron (Interview, February 20, 1986). Further, the black belt, the silver buckle, and he "veil" worn by some staff were reminiscent of an era past, and the senior administrative personnel at the Ministry of Health still wore uniforms four out of five working days. Nurses were subservient for so long in their history in terms of nursing as a profession, in their role as women, and their colonial heritage that the senior administrative nurses were essentially compliant. An interviewee stated:

> Uniform is a hang-over from the British. We are not compelled to wear it but the previous Minister of Health (a male, medical doctor) said he liked to see his nurses in uniform. We are still given uniform material and an allowance for doing so including laundry. If one were given a comparable amount [salary] one may not do so. There are no provisions for 'mufty.'* On Fridays we wear our ordinary clothes (January 13, 1986).

Added to these many aspects of the colonial influence, which were predominant in nursing practice, was that of the instructional staff. All the nursing instructors were prepared on British lines whether trained locally or in the United Kingdom. Their post-basic education acquired at UWI primarily, with a few at North American universities, provided a possible avenue for tempering the British influence but because nursing instructors were a scarce commodity they taught the theoretical content rather than the practical. Clinical supervision by them took the form of consultation mainly due to the high teacher/student ratio. Consequently, the direct practical supervision was left to the less qualified clinical instructors and the ward staff whose background and experience were of the British tradition.

Credit must be given to the senior personnel in the Nursing Division who had made valiant efforts in the face of overwhelming odds to ensure that supervisory staff received in-service education.

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*Ordinary clothes.

However, the constant shortage of staff meant further student deprivation of adequate supervision and was a possible adverse factor in student performance in the registration examinations. Additionally, because service needs were paramount student learning experiences did not always correlate with theory which hindered effective learning.

This discrepancy of what was taught in theory and what obtained in practice would be a contributing factor in the lack of success of students in the registration examinations. While this discrepancy was, to some extent, a reality in nursing programs internationally, it was of greater magnitude and assumed greater proportions in Trinidad. The sophistication of the curriculum in its North American orientation and its forward-thinking content was a marked contrast to the nursing service area which remained essentially as it was in the colonial era, maintaining the inherited British pattern of functional nursing and supervision of students by ward staff with insufficient numbers of instructors. It should be mentioned that while the organization of nursing service and education is attributed to the British because they were the colonizers, that pattern was not restricted to either Trinidad or Britain. It was international. The United States and Canada, in particular, had experienced similar features in their earlier histories because of the impact of the British system in those metropolitan countries. This, however, does not detract from the main argument which was that the practice area retained its colonial elements in the 1980s.

The nursing program in the post-colonial era, then, had undergone major revisions in its theoretical content reflecting North American ideas and values blended with substantial indigenous features, while the practice area retained the British traditions with nursing education subservient to nursing service. By 1986, basic nursing education had the following characteristics:

1. A program that was three years in length with two streams--general nursing or psychiatric nursing. The first 18 months were shared in common and the last 18 months were spent in general nursing or psychiatric nursing. The former leading to registration, as a registered nurse and the latter as a registered psychiatric nurse, with the Nursing Council.

2. A curriculum which was expressed in a well-written document highly influenced by North American ideas and beliefs yet incorporating significant indigenous content.

3. An apprenticeship system from the colonial period, with blocks of study where students spent varying amounts of concentrated time learning theory, followed by extended periods of clinical practice supervised by clinical instructors and ward staff.

4. Nursing instructors provided consultation and, to a lesser degree, some supervision but their prime responsibility was the teaching of theory. These instructors received post-basic preparation at universities in the Caribbean primarily, and to a lesser extent the United States and Canada.

5. The clinical instructors and ward staff did not have advanced education at universities; the former were prepared either in formal clinical instructor programs in Britain or local continuing education

programs. Some of the ward staff may have been involved in local continuing education programs.

6. Students received practice in a variety of community settings including six weeks of community health, psychiatric, and obstetrical nursing.

7. Examinations followed a modification of the inherited British system with theoretical and practical Examinations throughout the three-year program.

8. A significant indigenous feature was that students were paid employees in the Civil Service and were represented by the Public Service Association, the bargaining agent for all Public Service employees.

In summary, the main argument in the analysis of data in this chapter has been twofold. First, to demonstrate that during the colonial era there was a lack of planning to prepare adequate numbers of local nurses with the skills necessary for assuming leadership roles in service and education which were required to meet the needs of the country. This situation was perpetuated in the post-colonial era despite efforts to remedy the situation due to psychological and administrative factors inherited from its earlier period; but as well there were political and economic factors in the era of the national government that militated against correcting the problem. These were related to the image, status, and lack of power of nursing as a predominantly female group, and the nature of policy-making adopted by the government which tended to promote incremental rather than radical changes. It was further posited that these economic and political forms adopted by the national government were a reflection of those of its metropolitan colonists.

Despite these restrictive conditions, the nursing leadership in the colonial era had achieved registration for nurses to ensure standards of quality in education and practice. In the post-colonial era, they initiated staff development programs to enhance the clinical, managerial, and instructional skills of nurses. Further, the university program, projected for the Mount Hope Medical Complex, was an attempt by the government to prepare future nurse leaders. While it was a small step in the right direction, it would require greater commitment on the part of the government to ensure funding for a substantial number of nurses to be prepared, in order to administer the education and practice of nurses, so that health care could be effectively delivered in the nation.

The second aspect was to demonstrate that while British ideas and values were paramount in the colonial era, with the advent of self-government and independence, the government's strategy encouraged investments from the North American metropoles and loans from IADB and World Bank. These were seen as necessary to growth combined with local input and control. This approach facilitated the entry of the United States and Canada in the development of the country thus bringing North American ideas and values into the entire fabric of the nation to be combined with the inherited British influence. Consequently, in the health care field, there was considerable North American involvement in the development and implementation of the National Health Plan. Similarly, changes in nursing education were greatly influenced by these metropolitan ideas. The nursing program by 1986, therefore, reflected a blend of North American, British, and indigenous elements with the former two predominant. Further, the basic preparation of the nursing leadership in service and education was based on the British tradition, with post-basic preparation obtained in Britain. Nursing service, therefore, retained much of its colonial features and was slow to effect change. Since independence, with the advent of a post-basic program at UWI, Jamaica, the nursing leadership had shifted to obtaining advanced studies in the Caribbean with a small number prepared in the United States and Canada. Nursing education was shown to be dependent on the metropolitan countries for its ideas, values, and practices. It, however, was struggling to carve out its own unique features, albeit transformed by colonialism, to meet the needs of the Trinidadian society.

Summary

In this chapter, the findings were discussed relative to two major themes. The first was the demand, supply, and preparation for nursing leadership and the second focused on changes in the basic nursing program to improve standards. The economic, political, and social forces as well as the health services events which affected these themes in nursing education were also examined. The theoretical framework utilized in conducting the discussion was derived from theories of dependency and colonialism, and applied to the health care field and nursing education and practice.

CHAPTER VIII

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter provides a summary of the study and offers some conclusions and recommendations arising from the findings. The summary describes the development of nursing education in the post-colonial era, and is organized by addressing the research questions specifically. Additionally, some reflections are made on the value of the framework for studying nursing education in a developing country and in particular, Trinidad and Tobago.

A. Summary

The purpose of this study was to describe and analyze the development of nursing education in Trinidad and Tobago, with special emphasis on the forces that helped to shape the society, and consequently, nursing education.

Because of the nation's historical legacy of colonialism and its current linkages with the United States and Canada, a major area fundamental to the analysis was to determine whether the United States and Canada had superseded traditional British influences in determining health policies and specifically that of nursing education. This raised the question of whether or not the education of nurses could be autonomously determined to meet the needs of the people.

The enquiry was guided by two broad research questions and a theoretical framework was derived from the literature on dependency theory and theories of colonialism. The controlling concept in the theoretical framework used in this study was that since Trinidad and Tobago was economically dependent on the metropolitan countries for loans, technology, capital goods and technical aid (as indicated in Chapter IV, Section II), this dependency led to other forms of dependency which were reflected in the health care system and nursing education in the form of ideas, values, and practices derived from the metropolitan sources. Further, since Britain was the dominant metropolitan power for almost two centuries, the pervasiveness of the British ideas, values, and traditions persisted beyond the colonial era, and were reflected in the health care system, nursing services, and nursing education.

The socio-political context of the Caribbean and Trinidad in particular, as well as the health services events were presented.

The case-study methodology was employed in conducting the enquiry. The "reputational" approach was utilized to identify the important actors associated with the development of nursing education. In most instances, these actors were the nursing leadership in education and service. An interview technique which permitted respondents to express their views openly in an informal and non-threatening manner was used. Data from documents were used primarily in addition to the interview material. These formed the basis for an analysis of the findings within the study's theoretical perspective.

In the body of this document the evolution of nursing education was described by focusing on major societal forces and initiatives taken by government and the profession. These were subsequently analyzed within a dependency theory framework. In this section, the two major research questions and their subsidiary questions are restated and answered concisely.

1. What are the social, economic, political, cultural, and demographic forces that have helped to shape nursing education policies since independence?

    .1 What have been the major sources of British influence on nursing education programs in Trinidad and Tobago?

    .2 Have these been replaced by the United States and Canadian influence and, if so, by what mechanism is this being done?

    .3 What are the indigenous influences on nursing education?

    .4 Who are the principal actors with regard to health care policies?

    .5 Who are the principal actors with regard to nursing education policy planning and implementation?

    .6 To what extent is nursing education influenced or directed by health care policies?

    .7 What is the influence and/or input of nursing into health care policies?

The historical forces of colonization, slavery, the plantation system, and emancipation have shaped the West Indian societies and Trinidad, in particular. During the nation's history as a British colony, medical and nursing services were administered by personnel from Great Britain. Consequently, the health services, hospitals, and nursing programs were patterned on the British model. In the colonial era, positions of leadership were held by expatriates, but increasingly in the post-colonial era, scholarships were provided by the national government to educate local nurses in England to prepare them to assume the senior administrative posts. Further British influences in nursing education were evidenced in the block system, the apprenticeship pattern, the model of Practical and Theoretical Examinations for Registration Examinations, and registration reciprocity. Additionally, uniforms, nursing rituals, and the organizational pattern of nursing services remained essentially as they were in the colonial era. The recruitment of nationals trained in Britain to relieve manpower shortage in the 1960s provided yet another source of British infuence (Chapter VI, Sections D and E).

After political independence was achieved in 1962, the national government, in its attempt to become economically self-reliant and create a national identity, addressed the areas of public administration, education, the economy, and health care. Three Five-Year Economic Development Plans and a Fifteen-Year Education Plan were developed and implemented. The government eventually turned to external agencies as the World Bank, IADB, PAHO, and CIDA, for loans, technical and financial aid, and encouraged foreign investments (pp. 73-74). These organizations and agencies became the principal sources of North American influence on the development of the National Health Plan and on nursing education, as indicated in Chapter VI, pp. 117-123. Additionally, Caribbean economic cooperation was promoted which led to medical and nursing cooperative endeavors under the aegis of CARICOM (pp. 130-140). These health policies and plans had implications for content planning in the nursing programs. As well, the nursing leadership in developing the curriculum paid particular attention to tailor aspects relative to the local culture (pp. 174-175). Despite these efforts by the national government, colonial attitudes and structures remained entrenched in the society.

The Minister of Health, the Permanent Secretary, the Chief Medical Officer, the Chief Planning Officer, the Chief Nursing Officer, and the senior nursing and medical officers in the Head Office of the Ministry of Health were the principal actors in health care planning and policy-making. Further, at the implementation level nursing personnel were involved in the planning and implementation of health programs (pp. 123-126). With regard to nursing education, policy planning, and implementation, there was an overlapping and absence of clearly-defined, responsibilities between the roles of the Nursing Division (Ministry of Health), the Nursing Council, and the School of Nursing. Consequently, they were all involved in nursing education policy-making with the former two playing a major role (pp. 107; 141-177).

2. To what extent have the values and social organization of the society been reflected in nursing education policies and programs since independence?

    .1 In what way or ways are the values of the society expressed in nursing education?

.2 How are these values determined and who determines them?

.3 How is the prevailing class structure reflected in nursing education?

.4 Who are the decision-makers with regard to curriculum content?

The two major ethnic groups in the society were Negroes and East Indians. The former tended to live primarily in the cities where the two major hospitals were located, and the latter resided in the rural, agricultural areas. In the case of the latter, their religion, social organization in terms of caste, music, dress, and entire cultural system were East Indian which reinforced their separation from the wider community, as noted in Chapter IV, p. 53. Consequently, prior to Independence, mainly Negro women of the lower and middle class entered nursing. Since Independence, with the expansion of secondary education to the rural areas as a government priority for nation-building, and the gradual breakdown of religious Hindu practices, large numbers of East Indian women entered nursing, as pointed out in Chapter IV, pp. 75-78, Chapter V, pp. 87-88, and Chapter VI, pp. 224-225. Increasingly, middle class women of both racial groups constituted the majority of applicants.

The controlling attitudes and values in the Trinidadian society have been shaped to a large extent by the white European influence. The economic upsurge due to the oil boom in the 1970s led to a sudden societal affluence and a large middle-class was created whose values, tastes, and lifestyle were patterned after the American way of life. Material goods were valued and traditional values, considered colonial, were de-emphasized. These changes in value emphasis were reflected in nursing education through the practice area, with the result that punctuality and conforming to norms were translated as colonial and rejected. Thus, absenteeism occurred and a lack of caring and "rudeness" was evident.

While the theoretical content of the curriculum was designed by nursing educators and highly influenced by North American ideas and values, yet the practice area was slow to change and retained many of the inherited colonial traditions as the administrators and managers of nursing service were trained in the British tradition. Nursing education remained an apprenticeship system and there was a wide gap between the theory and practice. Additionally, since the welfare of the citizens was a national government priority, students became salaried government employees with union protection.

B. Reflections on the Value of the Theoretical Framework

Analyzing the data through an adaptation and application of key concepts of theories of dependency and colonialism was found to be particularly useful, enlightening, and applicable in this study. All of the interviewees acknowledged the influence of the British system on nursing education and its continued presence in the practice area up to 1986. Equally they emphasized and placed high value on the impact of North American technical assistance, ideas, and values on their own thinking and in the development of the new curriculum in 1981. However, it was often difficult to identify sources as British, North American or indigenous, particularly the latter as they were often transformed in the process of colonization. Further, because of the impact of Florence Nightingale on nursing internationally, many features were present in British and North American nursing at some point in time. Nonetheless, there were sources that could be clearly attributed to a particular influence. Functional nursing, the supervision of students by ward staff, the use of the veil, the black belt and silver buckle, the uniforms of the student nurses, study blocks, the preparation of instructors in programs in Britain, the recruitment of staff from Britain, the apprenticeship system, the utilization of theoretical and practical examinations are illustrative of the British influence. The major North American influence was its impact on the curriculum. This was evident in a sophisticated document for a three-year program incorporating experiences in community health, mental health and obstetrics. The growing tendency for further preparation at the Bachelor's, Master's, and Ph.D. level in the United States and Canada, and the beginning of nursing research through Surveys and Studies are further examples of the North American influence. The two outstanding indigenous elements were the two-pronged approach to basic nursing education leading to registration as either a general nurse or a psychiatric nurse, and the fact that all students and nurses were Civil Servants and represented by the same union. Other indigenous elements included the use of textbooks or social issues written about the Caribbean by Caribbean authors, and attention to local values, mores, foods and environmental sanitation conditions.

The theoretical framework helped to organize nursing events in a meaningful relationship to health services, social, political, and economic events in the society. It assisted in showing how developments in nursing education were a consequence of environmental conditions in society. It further permitted an examination of social, political, and economic events in society by demonstrating clearly a logical connection between such events with the progress, or lack of progress, in nursing education and service. It facilitated understanding of the dilemma that former small British colonies face in shedding their colonial past, as it demonstrated clearly how entrenched ideas, beliefs, attitudes, and practices in the society, and consequently in nursing education and practice, became over long periods of time which made it difficult to effect change. And, as such, it added further credence to change theories about the slowness and difficulty of effecting change. It was seen that even though the government used the strategy of structural reorganization of the health services to permit decentralization of decision-making yet the old attitudes persisted; consequently, actions remained centralized. Theories of change and policy-making could have been useful as well to analyze nursing education. The former may have provided further insight into the process of change at the individual, group, and organizational level. The latter was shown, on a small scale, to be useful in analyzing the pattern of policy-making followed by the government in all spheres of the society, including nursing education. The process of policy-making solely could have provided another perspective to view the data. Notwithstanding these musings, the theoretical framework employed for this study was, in the final analysis, the most appropriate as it applied to all aspects of the society and permitted peripheral consideration of these other theories. Further, it is generally acknowledged that no one theory represents "truth" or "reality" accurately or totally. The modification and adaptation of dependency theory permitted the researcher to get as close to "reality" as was possible.

C. Conclusions and Recommendations

In presenting the overall conclusions of the study and in consideration of the findings, recommendations are offered concerning new directions and future studies for nursing education in Trinidad and Tobago.

Nursing education in the age of independence had struggled to improve standards in order to meet the needs of the society but economic, political, and social forces in the society had, at successive periods, either advanced or hindered its progress. Besides these external influences, nursing leadership, regionally and locally, took the initiative to capitalize on the propitious periods to promote changes in the standards of nursing service and education. Considerable progress and great strides had occurred despite government's reluctance, at times, to heed the nursing leadership's requests for improvements in nursing service and the education of nurses. By 1986, 30 years after self-government was achieved, nursing education, while it was still an apprenticeship system, had a well-organized comprehensive nursing curriculum which was used by the Schools of Nursing to prepare students for entry to the nursing profession. It is to the credit of the local leadership, prior to and since independence, notwithstanding the many obstacles in their path, that they were able to develop a national nursing education program which reflected a blend of British, North American, and local influences. This was consistent with the values in the society at large which was eclectic consisting of colonial attitudes, North American values, and some indigenous features.

Trinidad and Tobago, like the other British Caribbean islands, has been anglicized over centuries of British rule. Because of its geographical location, in close proximity to North America, as well as the receptiveness of its economy to metropolitan investments, and the absence of any aboriginal traditions, cultural independence is not realistic or possible. Consequently, nursing education cannot develop autonomously to meet the needs of the people. What has occurred and continues to occur is the utilization of ideas and practices of the metropolitan countries and the modification and adaptation of some aspects to the island setting.

While the trend in metropolitan countries is toward considering areas such as midwifery and psychiatric nursing as post-basic programs requiring a foundation in general nursing, yet one has to exercise prudence when applying these ideas to the developing countries. This is not to deny the desirability of such a goal in the developed nations, but the concept needs to be tempered with common sense, practical reality, and approached with caution for the developing countries. In Trinidad, with the increasing evidence of mental illness and the concomitment dearth of mental health nurses, the current local model of single-trained psychiatric nurses with a common core of basic nursing education appeared to be a viable, realistic model in meeting the needs of the society at this time.

The use of single-trained, well-prepared midwives, or psychiatric nurses, need not be scoffed at, or seen as providing a lesser quality of care to clients, rather it could be viewed as more appropriately and realistically meeting the needs of developing countries. Too often the models used by Western societies are taken to be the paradigm without due regard for cultural, social, and economic circumstances of developing nations. Other developing nations are advised to consider the needs of their people in relation to the demand for midwives and mental health nurses. The discontinuation of both the single-trained midwife and the mandatory requirement of midwifery for nurses to practice, and as well, the reduced enrolment in midwifery programs for financial reasons could create future manpower shortage or cause a return to the single-trained midwives. It is, therefore, recommended that:

1. Continuous monitoring of the midwifery program be entertained.

While the basic nursing program included student experience in primary health care centers, graduates could not work in such centers without advanced preparation in both midwifery and community health. This resulted in a shortage of staff in community health, and the inability of graduates to work in primary health care centers.

2. Research into the possibility of streamlining educational programs to minimize this step-ladder approach for registered nurses to work in primary health care centers be considered.

3. Consideration of the proposed advanced nursing program for Mount Hope Medical Complex as the venue for planning and delivering such an option be entertained.

An outstanding conclusion that evolved from this study was the striking similarity in trends and issues in the development of nursing education in this society and in the metropolitan countries. Nursing programs, internationally, had gone through cycles of revisions in content with increases and decreases in length. Further, both in the service setting where students learnt to practice their art and in the educational arena, the problems experienced were the same. A lack of managerial and political skills, a dearth of well-prepared educators and senior nursing service personnel, and slowness of change in service settings were but a few. Fundamental to all of this is the basic fact that nursing is primarily a female group and suffers from all the problems that women, in general, have experienced. The struggle for nursing education to achieve its goals is akin to women's struggle for emancipation. Women, nursing, and all colonized people have much in common and that is that they are oppressed. A noteworthy observation was the absence of the role of doctors as a factor in the development of basic nursing education. This may be due to the limitations of this study where data were not sought on this aspect, nor did this issue evolve spontaneously to any great extent in interviews. Rather, where doctors were mentioned they were referred to in a positive light as noted in the development of the Nursing Council.

4. Further studies be conducted to include the role of physicians in the development of the nursing profession. These might yield useful insights.

Colonization had an effect on all the structures of Trinidadian society, but nursing education continued to be disadvantaged even with a national government in power. This was particularly blatant in the late 1970s, during the economic affluence, when scholarships for nurses for post-basic studies should have increased considerably but were negligible. Additionally, the Chief Nursing Officer's salary was far below her male counterparts in other branches of the Civil Service. Further evidence was seen in the plans for medical and nursing education in the late 1980s at the Mount Hope Medical Complex, where medical enrolment was targeted at 60 and nursing at 12. These few numbers of post-basic prepared nurses in a society where nurses deliver the vast majority of health care to clients in hospitals and the 102 health care centers throughout the country is ludicrous, if not lamentable. Since nursing care and its management at the unit level were often the butt of criticism, this can only be corrected when there are well-prepared nurses to manage units and educate staff and nursing students. With over 50 percent of health personnel in the Ministry of Health as nurses, it would seem to bear further consideration. This lack of attention by government to the recommendations of nurses about their education and practice, in order to improve standards of patient care, is another universal phenomenon related to the role of women, and nurses, specifically. Still, without intending aspersions to incumbents who are doing their best in the given circumstances, there is a dire need for articulate, assertive, well-prepared leaders in education and service who can compete on a par with their professional colleagues in other disciplines. This is particularly needed in the Central Office of the Ministry of Health where, as an interviewee suggested, "the time has come to put in the Head Office nurses who are capable by qualifications, training, by even physical presence to make the kinds of impact on the system that we need ..." (February 28, 1986).

5. The reinstitution of a series of scholarships, on a planned, continuous basis, for post-basic studies to prepare nurses for leadership roles in education and service be entertained.

6. Various funding sources such as PAHO or CIDA be approached to provide scholarships or grants for the further preparation of nurse-educators and managers.

7. Increased enrolment in the proposed post-basic program at Mount Hope Medical Complex be a priority.

8. Promotion by academic preparation, coupled with experience, should be encouraged and enforced for senior nursing positions in education and service, without regard to the seniority principle, of improved standards of student supervision and changes in the practice area are to be achieved.

9. To increase the self-esteem of nurses, and as a significant step towards improving the status of women the salaries of senior nursing personnel in the Central Office of the Ministry of Health need to be

revised, so as to be on a par with their counterparts in similar positions in the Civil Service.

The four central nursing roles in the Ministry of Health represented the nucleus and apex of decision-making for the nation. Yet, there were other levels of decision-making that could facilitate or hinder policies and plans. In particular, it was the powerful committee in the Ministry of Finance and Planning that ultimately held the purse strings. Consequently, lobbying and politicking become a critical ingredient for incumbents in those senior positions even more importantly than reporting to the Permanent Secretary. Because nurses and student nurses were members of the Public Service Association, it would seem essential that all nurses, but nurse educators and administrators, in particular, need those political skills to influence decisions and to get elected or appointed to key positions in the Association, rather than attempting to form their own union as suggested by some interviewees.

10. Workshops and courses could be developed to assist and provide nurses, and nursing leaders, in particular, with skills in assertiveness, lobbying, and the art of politicking. This content could also be included in all options of the proposed advanced nursing program at Mount Hope Medical Complex.

Another major conclusion was that the interrelated problem of salaried students and the apprenticeship system does not have an easy solution even though it seemed clear to many interviewees. Any proposed solution would require examination of the consequences, negative and positive, that would accrue prior to implementing such change. The suggestions for transferring nursing education from the hospital to an educational institution which was proposed by PAHO and supported by nurse educators, where students would have free tuition but no salary, is a change of major proportions. In a society, where unemployment among youth is high, the absence of an income, especially among female heads of households, could create greater social and welfare problems.

11. A phased process, over a period of a decade, is suggested because it would permit a gradual adjustment and accommodation to small changes. This approach would be in tandem with the general trend in the society towards incremental rather than revolutionary changes, and could be politically more acceptable.

(a) The first stage could be a change in organizational structure giving total authority and responsibility for the nursing programs to the Principals of the Schools of Nursing, with their positions on an equal basis with the Nursing Administrators (Matrons) of the hospitals.

(b) Another important stage would be to delineate clearly jurisdictional lines of responsibility between the Nursing Division, Nursing Council, and School of Nursing for nursing education policy-making and final decision-making.

(c) The nursing education plan proposed by the nursing leadership based on the recommendation of the PAHO study of 1968 could also be reassessed and redeveloped to be effected in small and progressive stages over the next decade.

In view of the significant progress that has been achieved regionally with regard to the development of Regional Nurse

Registration Examinations, and its potential benefit to improved patient care in the Caribbean,

12. The nursing leadership is enjoined to vigorously lobby the government for funds to aid in the realization of the goal of Regional Nurse Registration Examinations.

Finally, no attempt was made in this study to explore the area of folk beliefs, traditions, and practices and its impact on nursing education. That area in relation to basic, psychiatric, and midwifery nursing education is worthy of consideration and warrants further investigation.

13. Studies conducted into the role of folk beliefs and practices in the education and practice of nurses might be able to discern the nature of further indigenous features that exist, and their consequences for meeting the health needs of the society.

D. Implications for Nursing Education Administrators

It was envisioned that the implications proposed here would be original because of the unique nature of the development of nursing education in Trinidad and Tobago, but, after much deliberation, the suggestions offered are by no means new when viewed from an international nursing perspective. They, however, extend beyond nursing education per se to encompass ~~nursing~~ leadership in education and service as defined in this study. They are offered in the hope that they may prove to be of value to other developing nations who share a colonial heritage. The re-emphasis of directions already acknowledged by the developed countries can further serve to reinforce and underscore their significance for nursing internationally, and for Third World countries, in particular.

1. Nursing leaders need to be aware of the importance of economic, political, and social forces as well as the values in the society which impede or promote progressive changes in the education and practice of nurses. Such knowledge may assist them in recognizing the need to become more politically astute through the educative process in order to develop successful strategies for promoting changes in nursing.

2. This study demonstrated that the pattern of policy-making adopted by the government in other spheres of the society was consistent with their approach to nursing education. It would, therefore, be beneficial for nurse leaders to have an increased understanding of the policy-making process. This would further assist them in planning strategies for change.

3. Developing countries need to be cognizant of the persistence of colonial attitudes and practices as well as the influence of North American ideas on curriculum development. It, therefore, becomes vitally important when promoting changes to clearly and deliberately identify, preserve, and/or blend indigenous or aboriginal traditions and practices in nursing education and practice in order to meet the needs of their society.

E. A Final Commentary

Nursing education in Trinidad and Tobago has accomplished much of which it can be genuinely proud. The current leadership is fortunate to be a part of a new Caribbean Society that is emerging, where its own indigenous people control the State, where despite social and economic problems, it has maintained a stable political environment, and has attained improved standards of living and health. While nursing education has the formidable task ahead of it of constantly ensuring attention to: indigenous features in the curriculum, preparation of teachers, shortage of human and physical resources, greater control over student learning, and developing political acuity, yet, they need not suffer from any undue inferiority complex because of these factors. Rather, as Demas (1981) has pointed out, in relation to the West Indian society, and it is equally applicable to the nursing leadership in Trinidad and Tobago:

> All of this means that the New Caribbean Society must rest on an indigenous and not an imported ideological basis. If we are to create a distinctive society in the Caribbean, we must formulate the intellectual and moral bases of this society in light of our situation, our own history, our own possibilities and our own aspirations. The New Caribbean Man [Woman] must look inward for ideological inspiration (p. 321).

Nursing education in Trinidad and Tobago has begun slowly along that path.

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APPENDIX A

PERSONS INTERVIEWED IN TRINIDAD

Name of Interviewees and Positions

1.	Barnard, Jonathan	Coordinator of Community Psychiatric Services, Ministry of Health
2.	Beckles, Lynne	Secretary, Nursing Council of Trinidad and Tobago
3.	Benjamin, Cynthia	Principal, Community Health Training School, Arima
4.	Dolly, Berenice	Former President of the Registered Nurses Association and the Nursing Council; Retired Nurse
5.	Duke, Beulah	Instructor, Staff Development, and President of the Nursing Council
6.	Fields, Lucy	Former Director of Institutional Nursing, Ministry of Health, and Senior Tutor, Retired Nurse
7.	Foster, Kathleen	Acting Director, Institutional Nursing, Ministry of Health
8.	Foster, Lenore	Coordinator of the Nursing Assistant Program, Port-of-Spain General Hospital
9.	Foster, Valerie	Chief Nursing Officer, Ministry of Health
10.	Grayson, Jean	Coordinator, Staff Development Program, Port-of-Spain General Hospital
11.	Hargreaves, Evelyn	Former President of the Registered Nurses Association and the Nursing Council; Community Nurse
12.	Harry, -	Planning Officer, Ministry of Health
13.	Hilaire, Cora	Nursing Instructor, Community Health Nursing, Community Health Training School, Hume
14.	Holford, Jacqueline	Principal, School of Nursing, Port-of-Spain Hospital

15.	Julien, Marjorie	Matron, Port-of-Spain General Hospital
16.	Kirton, Jean	President of the Registered Nurses Association; Nursing Instructor
17.	Knights, Wilfred	Former Director of Health Planning, Ministry of Health
18.	Maynard, Glenda	Principal Medical Officer, Community Services
19.	Quamina, Elizabeth	Chief Medical Officer, Ministry of Health
20.	Sealy, Karen	Director of Planning, Ministry of Health
21.	Taitt, Tilma	Director of Nursing Education, Ministry of Health
22.	Wardrop, Ena	Director of Community Nursing, Ministry of Health
23.	Waterman, Ivy	Former President of the Registered Nurses Association; Retired Nurse
24.	Welsh, Beryl	Acting Principal, Midwifery School of Nursing, Port-of-Spain General Hospital

APPENDIX B

INTERVIEW GUIDE

1. What have been the major sources of British influence on Nursing Education programs in Trinidad and Tobago?

2. Have these been replaced by the United States and Canadian influence, and, if so, by what mechanism is this being done?

3. What are the indigenous influences on nursing education?

4. Who are the principal actors with regard to health care policies?

5. Who are the principal actors with regard to nursing education policy planning and implementation?

6. To what extent is nursing education influenced or directed by health care policies?

7. What is the influence and/or input of nursing into health care policies?

8. In what way or ways are the values of the society expressed in nursing education?

9. How are these values determined and who determines them?

10. How is the prevailing class structure reflected in nursing education?

11. Who are the decision-makers with regard to curriculum content?

GLOSSARY OF TERMS

CARICOM	Caribbean Community
CARIFTA	Caribbean Free Trade Area
CIDA	Canadian International Development Agency
CMO	Chief Medical Officer
CNO and PNO	Chief Nursing Officer; Principal Nursing Officer
CPTS or PTS	Central Preliminary Training School or Preliminary Training School
GDP	Gross Domestic Product
IADB	Inter-American Development Bank
Ministry of Finance	Ministry of Finance and Planning
Ministry of Health	Ministry of Health and Housing Ministry of Health and Environment
NIHERST	National Institute for Higher Education, Research, Science, and Technology
PAHO	Pan-American Health Organization
PNM	People's National Movement
Sister Tutor	An instructor or teacher in nursing education
TTRNA	Trinidad and Tobago Registered Nurses Association
UWI	University of the West Indies
WHO	World Health Organization